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Use of Plant-Derived Therapies in a Rural, Biracial Population in Mississippi

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Abstract

Exploring the use of plant-derived medicines has recently received much attention in both scientific and popular journals. A study conducted in central Mississippi on medicinal plants investigated the frequency of use, types of plants used, and symptoms treated. A randomly selected probability sample of 223 households found that over 70 percent of the adults used at least one plant-derived medicine during the past year. The most frequently used plants included lemon, aloe, castor, turpentine, tobacco, and garlic. Frequency of use varied by race with a higher proportion of African-Americans than Caucasians reporting use of a plant-derived medicine. Due to the possible presence of toxic compounds or potential drug interactions, it is recommended that health care professionals investigate the use of plant-derived therapies as part of the patient's medical history.

Key Words:
medicinal plants
African-American
health care-seeking

Introduction

Plant-derived medicines range from pure chemical entities available as prescription drugs (e.g., digitalis, morphine, taxol, etc.,) to standardized extracts, traditional herbal teas, and food plants for self-treatment. Promoting the use of traditional plant-derived medicines for self-treatment has become increasingly popular as evidenced by the coverage in articles in both scientific and consumer journals and the recent attention given by governmental health agencies, including the establishment of the Office for Alternative Medicine in the National Institutes of Health and the issuance of regulations on health claims for foods and herbs as dietary supplements by the Food and Drug Administration.[1-4] This recent attention, however, may not necessarily reflect the actual prevalence of use of such therapies in this country. For example, the research of Eisenberg, et al, reported in the *New England Journal of Medicine,* found that only three percent of Americans surveyed used herbal medicines within the past year.[5] Nevertheless, this particular prevalence rate may only be reflective of use

within technological societies, since the World Health Organization estimates that traditional plant medicines are the most frequently used for a majority of people in the world.[6] Even though reported use in the United States is low, in 1991 sales of herbal medicines in the United States were estimated at over one billion dollars.[7] In order to determine a prevalence estimate for rural Mississippi, a study was developed and conducted in rural Mississippi on the frequency of use of specific plants for self-treatment. Past studies of herbal therapies in the rural South have documented the consumption of a large diversity of locally gathered plant species as medicines.[8-11] These studies have emphasized the therapeutic uses, details of preparation and dosage, chemical constituents, and biological activities of the plants, but did not determine the general frequency of use of plant-derived medicines in the population nor the frequency of use of specific plant remedies.

Methods

The biracial population selected for this study was a three percent random cluster sample of households in rural, central Mississippi. Of the 223 occupied households contacted, response from one or more adults (aged 18 years and older) was achieved in 210 households for a 94.2 percent response rate; in total, 251 adults were surveyed in Spring, 1993. The questionnaire was administered by a trained interviewer and collected information on demographic, socioeconomic, and health variables as well as on the medicinal use and knowledge of 25 common medicinal plants and the disease or site specific symptoms treated by these plants. Selection of the 25 medicinal plants was based upon information from a previous survey identifying them as the most common plants used. In addition to the 25 specific plants, inquiry was made about any other plants known of or used by the respondents to treat specific diseases or symptoms.

Results

Table 1 *(above right)* examines the use of medicinal plants in the past year by race and age. As shown, 70.9 percent of the surveyed population used at least one plant-derived medicine during the past year. Distributions by both race and age were statistically significant in that a higher proportion of African-Americans than Caucasians and a higher proportion of those aged 45-64 years than those aged 18-44 years or 65 years and older used plant-derived medicine in the past year. As indicated, 30.7 percent of the surveyed population used one plant-derived medicine during the past year, 20.3 percent used two, and 19.9 percent used three or more. Here, the distribution by race was significant in that a greater proportion of Caucasians used only one plant-derived medicine, while a greater proportion of African-Americans used three or more; distribution by age was not significant.

TABLE 1
USE OF PLANT-DERIVED MEDICINES[1,2] IN THE PAST YEAR

Demographics	Percent Who Used Any Plant-Derived Medicine[3]	Percent Who Used 1, 2, or More Medicines[4]		
		1	1	3-7
Total Population (n=251)	70.9	30.7	20.3	19.9
Race				
African-American (n=123)	78.1	22.0	26.0	30.1
White (n=128)	64.1	39.1	14.8	10.2
Age				
18-44 Years (n=69)	75.4	27.5	24.6	23.2
45-64 Years (n=70)	81.4	35.7	20.0	25.7
65+ Years (n=112)	61.6	29.5	17.9	14.3

[1] Percent of the population who used plant-derived medicines.
[2] 25 different plant-derived medicines were used in the past year.
[3] Distributions by both race and age are significant at the $P<0.05$ level.
[4] Distribution by race is significant at the $P<0.001$ level. Distribution by age is not significant.

Table 2 *(top of opposite page)* illustrates the most frequently used plant-derived medicines, i.e., those used by at least ten percent of the population in the past year. Ranked from highest to lowest, the most frequently used plant-derived medicines were lemon, aloe, castor, turpentine, tobacco, and garlic. Use was significantly associated with race for all but one of these six plants, tobacco. Specifically, African-Americans indicated higher use of lemon, castor, turpentine, and garlic, whereas Caucasians indicated higher use of aloe. In addition to these plant-derived medicines, other plants were used less frequently for self-treatment; these included mistletoe, poke, sassafras, and willow.

Table 3 *(bottom of opposite page)* explores the most common diseases or anatomical sites reported as reasons for using plant-derived medicines. By rank order from highest to lowest, these included infectious/respiratory, skin, insect/parasite, cardiovascular, and gastrointestinal diseases or symptoms. As indicated, both acute and chronic conditions were identified as reasons for self-treatment with medicinal plants.

TABLE 2
USE OF THE MOST FREQUENTLY MENTIONED PLANT-DERIVED MEDICINES[1,2] IN THE PAST YEAR

Plant-Derived Medicine	Total Population	Race	
		African-American	White
Lemon[3]	47.4	62.6	32.8
Aloe[4]	27.1	18.7	35.2
Castor[3]	13.6	26.2	1.6
Turpentine[4]	11.6	18.7	4.7
Tobacco[6]	10.0	8.9	14.1
Garlic[5]	10.0	14.8	5.5

[1] Percent of the population who used the most frequently mentioned plant-derived medicines.
[2] Plant-derived medicines listed are those for which usage rate in the past year was ten percent or more.
[3] Distribution by race is significant at the P<0.001 level.
[4] Distribution by race is significant at the P<0.01 level.
[5] Distribution by race is significant at the P<0.05 level.
[6] Distribution by race is not significant.

Discussion

As stated earlier, WHO and Eisenberg reported different estimates of herbal medicine use throughout the world and in the United States, respectively, possibly reflecting the Third World status of the majority of the world's population. The results of this survey in rural Mississippi more closely reflect those reported by WHO in that more than 70 percent of this biracial population used plant-derived medicines in the past year. Utilization rates of the formal medical care system in central Mississippi are similar to those found nationally.[12] However, as evidenced by this study, self-treatment, or more specifically the use of plant-derived medicines, is an important adjunct to medical care in central Mississippi. The racial distribution patterns observed in this data may possibly reflect population cohort differences in this health care-seeking behavior, i.e. plant-based self-treatment may be one particular therapeutic path that is differentially selected. Also, the particular age distribution found may demonstrate that the practice of using plant derived self-treatment is not solely a behavior exhibited by the elderly, or that cohort usually associated with having knowledge of more traditional behaviors.

TABLE 3
MOST COMMON DISEASES OR SITE SPECIFIC SYMPTOMS TREATED USING PLANT-DERIVED MEDICINES[1] IN THE PAST YEAR

Disease or Site Specific Symptom	Total Population	Race	
		African-American	White
Infectious/Respiratory	43.4	48.0	34.4
Skin	20.0	11.4	36.6
Insect/Parasite	11.4	9.1	16.0
Cardiovascular	8.8	10.6	5.3
Gastrointestinal	8.8	8.7	2.3

[1] Percent of total diseases/symptoms given as reasons to use plant-derived medicines by those who used these medicines in the past year.

Self-treatment with plant-derived medicines is a widespread practice in the rural South. Plants contain thousands of biologically active compounds, a significant number of which have become the prototypes for most all drug classes. However, a number of plants, including those used in herbal teas, could also contain potentially toxic compounds.[13-14] The use of self-treatment as the first attempt at therapy may potentially delay more effective allopathic medical treatment, and plant-derived medicines, if used concomitantly with prescription medicines or over-the counter medications, may cause drug interactions. Although the use of self-prescribed plant therapies poses some potential risks, potential benefits are also a possibility and must be evaluated before the health impact of the use of plant-derived medicines can be determined on a scientific basis.[15-16] Based on these data, it is recommended that the patient's medical history include a focus on plants used in self-treatment practices.

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Inguinal Hernioplasty with Polypropylene Mesh

Jyoti Arya, B.A.; Richard Jennings Field III, M.D.; Richard Jennings Field, Jr., M.D.
Field Hernia Institute, Field Memorial Community Hospital
Centreville, Mississippi

Introduction:

Inguinal hernias are a commonly encountered problem in any medical practice. It has been estimated that between ten and fifteen percent of adults will develop a hernia. Men are twelve times more likely to develop hernias than women and by the age of seventy five approximately forty percent of men will have a hernia. An inguinal hernia seldom causes immediate problems for the patient. Often a small bulge in the groin that goes away upon reclining is noted for a few months before being brought to the attention of a physician. Many patients are hesitant to fix an asymptomatic hernia due to a poor under standing of the complications of untreated hernias, fear of the operation and pain, and disability during the recovery period. Unfortunately many physicians also consider asymptomatic hernia repairs unnecessary and fail to follow up with patients or refer them for treatment. The complications of an untreated hernia can be disastrous. As time passes the hernia defect may enlarge and bowel may become incarcerated. With long-standing hernias the abdominal defect may become so severe that loss of abdominal domain may occur, making it impossible to close the abdomen without a large prosthesis. Every year a few people die needlessly secondary to intestinal strangulation and sepsis from ignored and untreated inguinal hernias.

Hernia repair today is a very safe and effective operation. Many patients can be treated as outpatients who receive their operation in the morning and leave the hospital that afternoon. The majority of inguinal hernias can be performed under regional anesthesia which decreases the operative risk and permits testing of the adequacy of repair prior to closing.

Currently at the Field Hernia Institute, inguinal hernia repairs are performed using a polypropylene mesh patch and plug modeled after the Lichtenstein method.

Fig. 1: Shown with permission from the Lichtenstein Hernia Institute, Los Angelos, California.

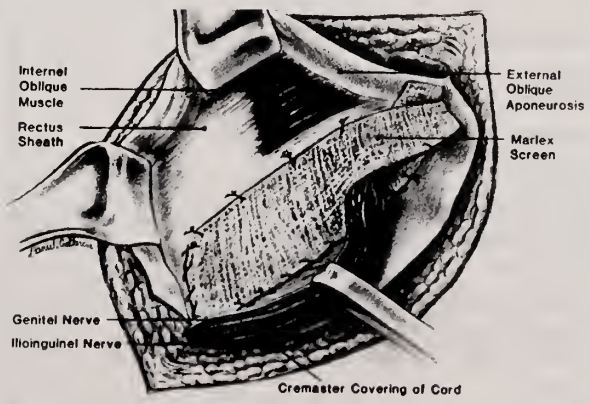


Fig. 1: Completed tension-free repair. (A) internal oblique muscle; (B) mesh patch; (C) external oblique muscle; (D) rectus sheath; (E) inferior cremaster bundle containing genito-femerol nerve; (F) spermatic cord.

The majority of repairs are performed on an outpatient basis within a wide age range and on all patients regardless of weight. Here we report the results of fifty five inguinal hernia repairs with polypropylene mesh.

Results:

During the years 1986-1993, a total of fifty five patients underwent polypropylene mesh inguinal hernioplasty at the Field Memorial Community Hospital.[Table 1] The patients ranged from seventeen and eighty nine years of age, with the average male age of fifty six and female age of sixty five. The majority of patients receiving hernioplasty were men totaling eighty nine percent. In thirty five percent of patients the inguinal hernia occurred bilaterally, thirty eight percent on the right only and twenty seven percent on the left only. Among the hernias which were present on the right forty three percent had both a direct and indirect component, thirty eight percent were indirect only, and nineteen percent were exclusively direct. Of the left sided hernias sixty seven percent were both direct and indirect and thirty three percent were entirely indirect.

Twenty six patients underwent outpatient hernia repair and left the hospital that day, nineteen patients were discharged the following morning, and ten patients stayed for between two to six days before discharge.

Male	**89%**
Average Age (17-85)	56 years
Female	**11%**
Average Age (38-89)	65 years
Bilateral Hernias	**35%**
Right Sided Hernias	**38%**
Indirect	38%
Direct	19%
Indirect and Direct	43%
Left Sided Hernias	**27%**
Indirect	33%
Direct	0%
Indirect and Direct	67%
Recurrent Hernias	**13%**
Left Sided	4 out of 7
Right Sided	2 out of 7
Bilaterial	1 out of 7
Incarcerated Hernias	**11%**
Left Sided	1 out of 6
Right Sided	5 out of 6
Average Length of Hospital Stay	0.93 days average
Outpatient Surgery	47%
One Day	35%
Two to Six Days	18%
Average Operating Room Time	64 minutes average
Unilaterol Procedures	50 minutes
Bilateral Procedures	79 minutes
Multiple Procedures	104 minutes
Anesthesia	
Regional	73%
Spinal	11%
Epidural	16%

Table 1

The average operating room time was sixty four minutes for all cases. Unilateral hernia repairs took an average of fifty minutes to complete. Bilateral procedures required seventy nine minutes and multi-procedure cases took an average of one hundred and four minutes.

Regional anesthesia was used in seventy three percent of cases, sixteen percent of patients received epidural anesthesia, and eleven percent received spinal anesthesia. Eighty four percent of patients received perioperative antibiotics consisting of either Cefotan, Unisyn, or Kefzol.

In ninety one percent of patients an approximately 10 x 12 cm piece of polypropylene mesh was tailored to repair the hernia defect and a small piece rolled into a "plug or umbrella" and placed into the inguinal canal. Nine percent of patients received a Gortex patch with a polypropylene plug. Seventy six percent of the cases were uncomplicated hernias and electively scheduled. Thirteen percent of the cases were performed for recurrent herniation. Eleven percent of the cases were complicated by intestinal incarceration at the time of hernia repair. In five out of the six patients incarceration occurred on the right.

Six patients underwent an additional electively scheduled procedure at the time of hernioplasty. One patient underwent a cholecystectomy, another a procedure for hemorrhoids, and three patients received a transurethral resection of the prostate secondary to benign prostatic hypertrophy.

A total of five patients experienced complications. Two patients developed hernatomas, one requiring re-exploration and ligation of a branch of the inferior epigastric artery; the other patient resolved with observation. Two patients developed a localized cellulitis and were successfully treated with a seven day course of antibiotics. One patient developed a recurrence within two weeks. This patient had undergone repair of a right femoral hernia and bilateral recurrent inguinal hernias.

Discussion:

The word hernia comes from the Greek word hernios which means bud. In Latin hernia meant a rupture or tear. Today the hernia generally means a protrusion of peritoneum or abdominal viscera outside the abdominal cavity through a natural or acquired defect. How is such a defect in the abdominal wall generated? Unfortunately, the "defect" is an aspect of normal human anatomy. Hesselbach's triangle is the region in the groin that is bounded by the internal oblique and transversus abdominus

musculoaponeurotic arch superiorly, the inferior epiqastric vessels laterally, and Cooper's ligament. Uncomplicated patients were treated as outpatients without difficulty.

The incidence of recurrence is very low, 1.8% in this series. The patient who developed the only recurrence developed it within a week. He is a seventy five year old male who had undergone a primary bilateral hernia repair by different surgeons several ycars prior. He presented with bilateral recurrences and a primary left femoral hernia. Patients with multiple and recurrent hernias are more difficult to treat and often have an underlying collagen defect. It is important to perform these cases under local or regional anesthesia so that one can clearly identify the hernia defect prior to its repair. Our only reoccurrence happened because we failed to identify one of the facial defects at the time of repair due to the fact that it was done under general anesthesia.

There were four other complications, two hematomas and two patients with wound skin infections. Wound hematoma complicates the post operative course of seven percent of patients at several centers nationally. We were fortunate to have only 3.6% of patients develop a hematoma. One patient required re exploration and ligation of a branch of the inferior epigastic artery, the other resolved without intervention. Two patients developed localized skin infections which resolved with antibiotics. At other centers nationally the incidence of wound infection is approximately one percent.

The benefits to the Lichtenstein method of hernioplasty are many, namely the ability to be performed on an outpatient basis and the ability to use local anesthesia. By avoiding a hospital stay patients and hospitals save money, and many patients report feeling more comfortable at home, thereby decreasing anxiety. The use of local anesthesia and intravenous sedation decreases operative risk associated with general anesthesia and most patients tolerate the procedure without difficulty. The positioning patch and strength of the repair can be tested by asking the patient to cough or valsalva. Intraoperative testing helps to reduce the incidence of recurrence due to insufficient operative repair.

Inguinal hernioplasty with polypropylene mesh patch and plug can be performed with good results by surgcons within local communities who have been trained in the technique. The ability of patients to receive quality carc in rural areas is possiblc and evident by the results of this review. The basic outpatient nature of inguinal hernioplasty makes receiving treatment at ccnters near to paticnts' homes all the more important.

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Journal of the Mississippi State Medical Association
Volume XXXVII, Number 1

Coding Workshop Schedule

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•What is the physician's role in the coding process?

DATES & LOCATIONS:

Tuesday, Feb. 20th	Wednesday, Feb. 21st	Thursday, February 22nd
Executive Inn	Ramada Plaza	Holiday Inn University
1001 N. Gloster	I-55 N. & County Line Rd.	3400 Hwy. 49
Tupelo, MS	Jackson, MS	Hattiesburg, MS

REGISTRATION INFORMATION:

Enrollment fee: $110.00 per member participant
$160.00 per non-member participant
The fee includes program, workbook, refreshment and lunch.

CALL FOR CONFIRMATION: 354-5433 OR 800-898-0251

128th Annual Session Scientific Exhibits

The MSMA 128th Annual Session will be held May 1-5, 1996 in Biloxi, Mississippi at the Grand Casino Resort Hotel. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or Fax the following information to (601)352-4834.

The request for exhibit space should include:

(1) the title of the exhibit;
(2) the author(s) of the exhibit;
(3) an estimate of the amount of exhibit space needed (MSMA will provide a table only - all other materials are the responsibility of the exhibitor); and
(4) a brief synopsis of the subject to be exhibited.



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D. Stanley Hartness, Jr., MD

The President's Page

Preaching to the Choir

"Asking directions is a sure sign of weakness." I tried to reason. "Besides, those 7-11 clerks have more to do with their time."

As trivial as it may seem, Beth and I have had some of our more vigorous disagreements over that most universal of male faults: Being directionally challenged! This shortcoming--plus disputes over hanging pictures--has brought us to the brink of divorce, but our union has endured.

It seems that all married folks disagree from time to time. Actually a marriage in which no quarreling at all occurs may well be one that is dead or dying from emotional undernourishment. If a couple cares, they probably disagree.

Our family of medicine is presently beset, however, with disagreement, dissension, and discord which threaten to undermine the basic principles of our profession. And at the heart of the matter seems to be the perception that organized medicine, namely the AMA, no longer represents the interests of its grassroots membership.

Troublesome to me with my presidential ear to the ground is that most of these rumblings of discontent arise from physicians usually conspicuous by their absence from local medical society or state medical association activities, not to mention meetings on the national level. Obviously fueling this smoldering situation is the market-driven health system reform guided not by democratically elected officials or public planning agencies, much less organized medicine. This pervasive reform portends unprecedented changes in the

traditional practice of medicine in the United States.

Physicians are being asked to move from "the corner grocery store concept to Wal-Mart." This means that we are often forced to rely on others to digest large quantities of business, legal, and information systems data and summarize it for us—a situation many of us find at odds with our usual situation of control.

Despite the diversity of its members, it is to this end that the AMA intercedes in our behalf in the art, the science and the business of the practice of medicine to promote unity of purpose. As a matter of fact, a current Study of the Federation project by the AMA has as its goal the identification and pursuit of new, more effective ways for organized medicine to work together as we approach the 21st century.

By the same token, MSMA is an inclusive organization that solicits your input, participation, and even dissenting opinions. And contrary to popular opinion, our leadership is composed not of "good ole boys" but rather reflects the commitment, dedication, and interest shared by individual physicians in areas of professional autonomy, patient advocacy, and public accountability.

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVII, NUMBER 1
JANUARY 1996

SERENDIPITY AND THE JOINT PRACTICE COMMITTEE

"Serendipity-The Discovery of Wonderful Things Not Sought"
- Webster

Let me tell you a little story. This fall your MSMA Council on Medical Services set themselves about the task of rejuvenating the Joint Practice Committee. This ad hoc (or special) committee is charged "to review the status of joint practice arrangements between physicians and nurse practitioners and to expedite joint promulgation by the Mississippi State Board of Medical Licensure and the Mississippi Board of Nursing of rules and regulations governing protocol arrangements between physicians and nurse practitioners. The committee shall also review quality assurance standards of nurse practitioners and supervising physicians and advise the state boards of the status of these review activities."

These high-sounding words add up to one thing, this Joint Practice Committee is going to be one extremely important and much needed group effort to ensure that the very highest calibre of medicine possible continues to be practiced in the state of Mississippi as we enter the 21st century.

Mind you, this committee was not revived simply for the sake of having another committee on board. There was a crying need, a virtual abyss if you will to foster a mechanism of addressing the concerns that have arisen in the wake of the recent exponential proliferation of joint practice settings throughout Mississippi.

Several "horror stories" were brought to the attention of the members of the Council on Medical Services. We heard tales of physicians in Memphis signing protocols for nurse practitioners on the Mississippi Gulf Coast, of senile, non-practicing physicians signing off on charts, and stories of physicians who supervise virtual stables of over a dozen nurse practitioners. Were these real problems or a product of some rumor mill? There was no investigative body equipped to answer this question.

We were not able to identify an existing facile or effective method of jointly addressing quality assurance in these situations. There was no coordinating body between the MSMA and MNA and the licensure boards governing them. Make no mistake, this committee has the potential to fill this void.

By definition the Joint Practice Committee will be composed of one member of the MSMA Council on Medical Services (Dr. Nancy Tatum will serve us in this post) and one member of the Mississippi Nursing Board of Directors who shall serve as co-chairs; one member of the Board of Medical licensure; one member of the Mississippi Board of Nursing; five MSMA member physicians, at least three of whom have had within the past three years a protocol arrangement with a nurse practitioner in Mississippi and five MNA member nurses, at least three of whom are licensed nurse practitioners and who have had in the past three years a protocol arrangement with a Mississippi physician.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

The Council on Medical Services has made the following five physician appointments: Linda Chidester, M.D., Dewitt Crawford, M.D., Dean Cromartie, M.D., Joseph M. Ross, Jr., M.D., and Carolyn Gerald, M.D. The first meeting is planned for December 20 at the MSMA headquarters building in Jackson.

Now, as Paul Harvey so often says, here's the "rest of the story." While your council was searching to fill these five posts in accordance with our self-imposed job description, a unique Mississippi physician was recommended to us. The person who nominated her said "this woman will be great for this committee. She is a real-life embodiment of the ideal of a physician, what medicine should really be about, and she is in a joint practice environment." When he got through painting this idyllic picture I said, "Whoa, who is this person? I have to know more about her." I called her up and talked with her about the formation of the committee and asked to learn more about what she's doing over in the Delta. Sister Anne Brooks is an osteopathic physician who has practiced general medicine in Tutwiler since 1983. Sister/Doctor Anne Brooks has been a Roman Catholic Nun of the Order of the Holy Names of Jesus and Mary since 1955. Anne Brooks developed rheumatoid arthritis at age 18 and was confined to a wheelchair-crutches for some 17 years. After a long struggle she overcame this obstacle to become a school teacher and later principal for 17 years in various schools in Florida. During this time she did volunteer work after school hours at the Clearwater Free Clinic. She later left teaching to found the St. Petersburg Free Clinic (a licensed drug abuse treatment center). There she lived in a garage behind the clinic and was encouraged by Dr. John Upledger, a physician at the clinic, to go on to medical school. Sister Anne did just that and graduated in 1982 at age 44 with her D.O. degree from Michigan State University College of Osteopathic Medicine with the help of a National Health Service Corporation scholarship. This scholarship required her to serve 4 years in a medically deprived area. Fortuitously for us, this brought her to this tiny Mississippi Delta town. Anne said, "I was looking for the bottom of the barrel and Tutwiler was it." Well, Dr. Anne stayed her 4 years and thus far 9 more to boot.

Dr. Brooks and two nurse practitioners, both nuns, see an average of 630 ambulatory care patients a month at the Tutwiler Clinic. In addition to medical care, this team and their staff offers mental health counseling, literacy and GED classes, child care classes, summer programs for children, a thrift shop and even field trips for senior citizens. These nuns are dedicated to the idea that medical care is a human right and not a privilege.

Dr. Brooks has a CV that weighs about a pound and a half. (I had to make her send it to me.) Articles about her have been featured in numerous national medical and lay magazines. I got home one night and read through all these articles about her and I couldn't even sleep. How had I not known of her before? I wanted to meet her, I wanted to write about her. Suddenly I felt ashamed for wanting to actually make money as a result of people's illnesses and misfortunes. I longed to be more like her. But I'm afraid that making vows of chastity, poverty and obedience are quite out of the question for me. I expect I'll have to remain a guilt-ridden Baptist.

When Anne and I talked, I read to her the charge of the committee and then my bubble burst. I learned that Dr. Brooks was not currently a member of MSMA, because she couldn't afford the AMA dues. Of course, as it stands, this completely bars her from being a member of MSMA. The saddest part is that she truly wishes to be with us. That she cannot be is our loss.

Anne wrote me, "We serve such a highly indigent population in Tutwiler, and while I suppose one normally charges such memberships to practice , I have a hard time justifying it, when that money could be used to get medication for my pediatric patients."

Dr. Brooks is the only physician I know whose income is below the federal poverty level. Then, consider the fact that our required dues are around $900.00, a figure that represents nearly 20% of her annual income.

The point of my story now is not to rally for a reduction in MSMA dues for everyone. What is needed is a mechanism to waive our dues requirement for bona fide medical missionaries so that Dr. Brooks and others like her can be a part of our association. I would like to see them be full-fledged, active, voting members of our fold, not simply honorary members. These people need and deserve to enjoy the collegial environment that being an MSMA member provides. But, mostly, we need them. We need to share in their input, their ideas and experiences.

Dr. Brooks indeed would have been ideal to serve on our joint practice committee and she was ready and willing to do so. In my opinion her absence from our ranks only diminishes us. She would have served us as faithfully as she does the Lord and the Mississippi Delta.

After becoming interested in Sister/Doctor Anne Brooks and reading about her work I got all fired up to write a feature story on her for the MSMA Journal. She absolutely vetoed it. Anne said, in effect, that there were too many other doctors in the Delta (many MSMA members and others) who deserved recognition for their work more than she, and that she did not want to be singled out and have her "horn tooted" at risk of slighting others.

So Dr. Brooks, I didn't write the article about you that I wanted to. As you can see, it was about the Joint Practice Committee, MSMA membership and . . . . . Serendipity.

Dwalia South, M.D.
Editor

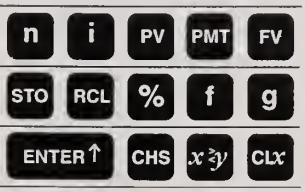
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NEWS

Delta Medical Society Holds Annual Meeting

Delta Medical Society held its One Hundred and Forty Fourth Semi-Annual Meeting in Cleveland recently and conducted a scientific as well as business session. Among the speakers were MSMA President, Dr. Stanley Hartness, who reported on current activities of the association and MSMA Delegate, Dr. Edward Hill who presented information about Congressional action on Medicare.

A scientific program was conducted and members heard three papers presented by: Drs. Joseph Terracina, Greenville; Nikhil S. Shah, Greenville, and Kenneth J. Hardy, New Orleans.

During its business meeting, the society acted to contribute $4,000 to Dr. Hill's upcoming campaign for election to the AMA Board of Trustees and voted to issue a challenge to MSMA's other component societies to match the contribution in support of Dr. Hill. The society also voted to support a single Medicare fee area for Mississippi and to inform MSMA of this support.

In other action the Society endorsed continuation of its annual contribution to the Caduceus Club. Members of the society also heard a report on public health concerns in the Delta as is customary at the semi-annual business meeting.

Newly elected and continuing officers of the society are: Drs. David Walt, Cleveland, Immediate Past President; W.L. Prichard, Indianola, President; Mack Gorton, Belzoni, President-elect; and Randy White, Greenwood, Secretary-Treasurer. County Vice Presidents of the socicty are: Drs. Scott Nelson, Bolivar; John G. Lucas, III, Lcflorc; William W. Dowell, Sunflower; Robert Bowman, Washington; and William Touchstone, Humphries.

National Immunization Survey Ranks Mississippi Sixth

Mississippi does a better job of protecting children against preventable diseases than 43 other states, a national survey confirmed Friday.

The National Immunization Survey (NIS) - the first single survey to compare state immunization levels - ranked Mississippi sixth in a tie with New Hampshire. Mississippi fully immunizes 83 percent of its two year-olds against diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella.

"Mississippi could become one of the first states to reach the nation's immunization goal for the year 2000 - immunizing 90 percent of all children before they reach age two," said State Health Officer Ed Thompson, MD, MPH. "The Tombigbee Public Health District surrounding the Starkville area already has surpassed that goal."

The NIS found national averages of immunization levels near 75 percent. State coverage rangcd from 61 percent to 88 percent.

Only five states - Connecticut, Hawaii, North Carolina, South Carolina, and Vermont - achieved higher immunization rates. All have higher per capita incomes than Mississippi.

In 1994, a *Journal of the American Medical Association* study concluded Mississippi's vaccine delivery program should become a model of what works best for rural states.

Common sense policies created Mississippi's success in immunizations, and practical uses of emerging technologies will ensure that success, Thompson said.

"We stick 'em while we've got 'em," Thompson said. "We avoid missed opportunities to immunize children by reminding parents about vaccinations when they come in for other things."

New technologies that allow clinics to share patient information will soon remind parents about immunizations before they make a clinic visit.

"Mississippi is creating a statewide immunization registry to track immunizations for parents, schools, and the medical community," Thompson said. "Computer networks will link public and private clinics to track a child's immunization schedule and remind parents through the mail when their children need immunizations."

Using the computer registry, a family from Biloxi might move to Batesville and misplace their personal immunization records, but the Batesville clinic could get the dates a child was immunized almost instantly.

For full immunization, children should make four visits to a county health department, community health center, or private physician. Children are vaccinated at two months, four months, six months, and 12 months of age.

continued from p.442...

Many two-year-olds without full immunization need only one more clinic visit for full protection, the NIS showed.

Survey results will assist CDC in awarding additional funds to states that have achieved improved immunization levels, CDC Director David Satcher, MD, PhD, told departments of public health.



The MSMA Board of Trustees held their annual fall meeting Saturday, December 9, 1995 at MSMA headquarters in Jackson. **Shown above:** ***Dr. Ellis Moffitt, director of the Disabled Physicians Commerce*** *gave his report.*



Left: ***MSMA President D. Stanley Hartness, M.D.*** *addressed the South Mississippi Medical Society at the Hattiesburg Country Club, Wednesday, December 13, 1995.*



Right: ***MSMA President D. Stanley Hartness, M.D.*** *converses with* ***South Mississippi Medical Society President Thad F. Waites, M.D.***



President-Elect Fred L. McMillan, M.D. entertained the Board of Trustees with dinner at his home the eve before the meeting. ***Dr. H. Vann Craig, M.D.*** *provided extra entertainment by giving* ***President Hartness*** *a special award for missing his flight to the AMA Convention in Chicago. It seems the two were so busy talking in the Jackson airport that Dr. Hartness boarded Dr. Craig's flight which was en route via Cincinnati. Once airborne, imagine Dr. Hartness' surprise when he found out he was not en route to Atlanta for his connecting flight. "You mean this plane isn't going to Atlanta!"*



A busy year finds ***MSMA President D. Stanley Hartness*** *journeying to Hattiesburg via Jackson for a medical society meeting in a delivery truck for his daughter's wedding supplies. Leaving the meeting, Dr. Hartness poses for a picture for the folks back home (everybody knows a president rides in a limousine). In this case the limo' was a prop funded by the Hattiesburg Country Club.*



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Future School of Health Related Professions building.

UMC to Build New School of Health Related Professions

The School of Health Related Professions (SHRP) at the University of Mississippi Medical Center has become the largest school on the Medical Center's Campus -25 years after its authorization.

"Enrollment has continually increased in SHRP over the past several years," said Dr. J. Maurice Mahan, SHRP dean. "Our current enrollment is 393. This constitutes an almost 67 percent increase just since the past five years."

Initially, according to Jack Gordy, SHRP assistant dean, very little serious consideration was given to the allied health professions in state higher education. But in his 20 plus years of working at the Medical Center, he has witnessed SHRP's birth and its rapid expansion. The Board of Trustees of State Institutions of Higher Learning, authorized the school in October, 1971.

Another turning point in the increased awareness of the importance of allied health, was SNAP, Statewide Network of Allied Programs, funded by a Veteran's Administration grant. Funding allowed for five additional staff for SHRP, then called the School of Allied Health Professions. These employees traveled the state providing preprofessional consultation and information at career fairs, in-service terminology seminars, educational programs, medical supervisory management, and introduction to the metric system seminars.

"We had a very fuzzy idea of what allied health was. There were few role models-none within the state," Gordy recalls. "When people thought of health care careers, they focused on becoming a doctor or a nurse."

Typically, the five made contact with 4,000-6,000 students each year at an estimated 200-400 sites within the state. Every junior, senior, and community college and major high schools were visited at least once per year. Also, Gordy says, close contact with minority institutions was established and has been maintained.

SNAP's objectives were to encourage students to pursue careers as allied health professionals, increase the level of awareness and the applicant pool in all programs in the School of Allied Health (SHRP) and to access the state's need for these health team members.

Funding for SNAP lasted from 1974-1981. Even after the funding stopped, SNAP continued, Gordy said.

"Actually SNAP never stopped. The funding ended, but SHRP continues to engage in these same activities, simply because SNAP was so significant in the development and progress of the school," he said. "Only now, the burden is transferred to the dean's office and the faculty in SHRP."

The school currently offers baccalaureate degree curricula in clinical laboratory sciences, cytotechnology, dental hygiene, health information management, occupational therapy and physical therapy and a certificate program in emergency medical technology.

Since 1957, 1,286 degrees and 399 certificates have been awarded in allied health programs.

"What I've seen is a school that has grown to meet the needs of Mississippi in terms of service and education," Gordy says. "I am most impressed by the leadership role the school has taken in allied health in this state."

SHRP was first to develop an occupational therapy program in Mississippi.

It took hospital-based certificate programs and strengthened and upgraded them to baccalaureate status and added new programs that were needed in the state. SHRP also has assisted other state schools in similar allied health program development.

"What makes my job fun is we're never sitting still," he said. "We're always looking at new programs, new ways of doing things and new activities." Growth has been so constant that $12 million in funding has been approved by the state for an academic building. The school now occupies what was once a men's dorm on Lakeland Drive and leases space in buildings across the street. Construction is slated to begin in 1996.

Dr. Mahan says that even more growth is anticipated. "We're pretty much at the projected number we thought we'd have for the new building. I'm not sure how much bigger we'll really get. We can't tell what's going to happen with Medicaid and Medicare, but we are market driven and flexible and able to meet the needs of a changing population. Programs, for instance," Dr. Mahan says, "have opened and closed over the years depending on demand. As long as the population needs to be served, we're going to be here to do that."

UMC Chosen for Papnet

Papnet, a computerized means of analyzing the pap test, will make the pap test a more reliable screening process for cervical cancer by reducing the false negative rate. False negative results are defined as reporting a smear as negative when cancerous or precancerous cells are really present. This state-of-the-art technology was used in a clinical trial at the University of Mississippi Medical Center (UMC), one of 10 nationwide sites participating.

Other sites include Johns Hopkins University, the University of Oklahoma, University of California at San Francisco and Los Angeles, University of Iowa, Ohio State University, Montefiore Medical Center in New York, and a large commercial laboratory in Las Vegas.

UMC was chosen as a participant because of its large annual volume (over 100,000) of smears, its computer ized cytopathology laboratory (allowing easy access to patient histories), and the Medical Center's designation as an academic health science center.

Papnet review stations are used successfully in Australia and England but await final FDA approval in the United States. More than 143,000 smears have been evaluated in the foreign market.

Statistics show that 15 percent of women in this country have never had a pap test. About 15,000 new cases of cervical cancer are diagnosed annually, and about 4,600 patients will die of their disease. According to some reports, many women with cervical cancer have never had a pap test.

"Cervical disease can be successfully managed by the gynecologist if detected in the early stages," says Zelma Cason, chair and associate professor of cytotechnology in the School of Health Related Professions (SHRP) at UMC.

She and Dr. Luciano Lemos have worked closely with the Papnet project. Cason and Dr. Lemos are both quite optimistic about the value of this technology on patient care.

"It has been very tedious, productive work," Cason says. "This is probably going to help a lot of women. Dr. Lemos calls Papnet the first major breakthrough in screening technology of pap smears, since the test was described by Dr. George Nicolas Papanicolaou in 1928.

"There have been several attempts to program computers to evaluate cytologic smears. Papnet allows interaction between the computer and the cytotechnologist-pathologist team.

This makes the cytotechnologist (a technologist speciaily trained to detect cancer cells) more at ease and more efficient. The more tedious and laborious part of their jobs will be done by the scanner, Dr. Lemos said.

Cells located far apart can be summarized and compared. In false negative cases, cells may be hidden and almost impossible for the cytotechnologist to find in a routine screening. With Papnet, however, representative cells are located and displayed.

"Papnet is very interesting, and the computer does the boring part," Dr. Lemos says. "Even the best cytotechnologist on a bad day can miss a case."

With Papnet, however, the cytotechnologist's performance would be enhanced and double-checked. There have been concerns that Papnet would decrease the need for cytotechnologists, but Cason says, "Not so."

"We still have to make the final evaluation with the microscope. Papnet simply identifies certain areas with which we should be most concerned. The cytotechnologist re-evaluates the smear and makes a diagnosis. Papnet does not diagnose."

The number of slides for re-evaluation could increase by 25 percent with Papnet. Thus, 20-30 percent more cytotechnologist time would be required. "Papnet will definitely increase the need for more cytotechnologists," Cason said.

In addition to making the papsmear evaluations more reliable, Papnet would be a plus when used as a teaching tool for cytotechnology students.

"It can only enhance what students are learning," Cason says. "They have to be more qualified when they walk out of our doors. This is the technology they'll use, and you can't just expect them to know how."

A three-day training workshop is provided to cytotechnologists who use the system.

Despite the many advantages Papnet seems to offer, price has been a recurring concern. The price of each pap smear could be raised by $5-$20.

"Hopefully, in time, those amounts will decrease," Cason says.

According to the findings from this clinical trial, an average of five percent of pap smears judged negative could be reclassified as atypical or suspicious. Fortunately, most the of false negative cases (80 percent) at UMC were reclassified as atypical but not cancerous.

"None of the women with so-called false negatives was at life-threatening risk since a future annual smear could detect the lesion if it progressed. Most of the "low grade lesions" regress. Some will go into a non-invasive state and remain dormant for another five years, at least," Dr. Lemos said.



Ms. Zelma Cason *at a Papnet station.*

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Mississippi Foundation for Medical Care



Dr. James McIlwain, Foundation medical director, *and* ***Dr. Alton Cobb, principal clinical coordinator,*** *demonstrate the importance of influenza immunization by volunteering to be first among the Foundation staff to take the flu shot. One of the Foundation's clinical improvement projects is directed at increasing the percentage of eligible Medicare beneficiaries immunized against influenza.*

The Foundation for Medical Care's clinical improvement project directed at increasing the percentage of eligible Medicare beneficiaries immunized against influenza this year attracted 25 provider collaborators from throughout the state.

The Foundation's Health Care Quality Improvement Program (HCQIP) has joined with a number of agencies sponsoring programs which encourage all eligible beneficiaries who do not have contraindications to the vaccine to be immunized.

According to statistics released by the Health Care Financing Administration and the Centers for Disease Control and Prevention, the influenza immunization rate in Mississippi's Medicare population for 1993 was 24 percent, lower than the national rate of 35 percent and also lower than other states in this region. Reasons suggested for low rates for vaccinations include the fact that immunizations are not part of routine medical care for adults as they are for children. Despite widely publicized campaigns last year, people may be unaware of the vaccine or of the potential dangers of the disease. Some people fear the shots will make them sick, although flu vaccines are made from inactive, noninfectious viruses.

The influenza project includes a unique emphasis on immunization of hospitalized patients. Several studies have shown some 40 percent of elderly persons who were hospitalized with influenza-associated respiratory conditions, and 65 percent of patients who died from the conditions, had been hospitalized during the previous

vaccination season but did not receive the influenza vaccine before discharge. These cases represent missed opportunities for prevention of influenza.

The Foundation provides each facility with CDC guidelines on influenza immunization and literature references reporting studies regarding immunization for hospitalized patients. Each facility develops protocols, plans and procedures for putting in place a program to immunize patients. In addition, each facility is offered the use of Epi-Info, a CDC developed computer software program for data entry and analysis. The Foundation also provides information on billing procedures for administration and the cost of the vaccine. Joyce Shearry serves as project manager.

Submitted improvement plans propose a variety of approaches for increasing influenza immunization for Medicare patients in the community. Each plan includes as one component the provision of vaccine to eligible inpatients.

Activities stimulated by these hospital-based projects to encourage the administration of influenza vaccine will be helpful in the countrywide efforts to increase the percentage of beneficiaries who are immunized.

In related activities, the Foundation staff has distributed brochures and other informational materials concerning influenza immunization throughout the state.

Organizations cooperating in the project include the state's carrier MetraHealth Part B; the AARP; the State Department of Health; representatives from home health agencies; End Stage Renal Disease Network 8; the Council on Aging; and the Lung Association.

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ARTIGUES, MICHAEL M., Mc Comb. Born Vicksburg, MS, Feb. 18, 1966; MD University of Mississippi School of Medicine, Jackson, MS 1992; pediatrics residency, University Medical Center, Jackson, MS, 1992-95; elected by South Central Medical Society.

AUSTIN, JOSEPH D., Vickburg. Born Greenville, MS, June 4, 1965; MD University of Mississippi School of Medicine, Jackson, MS 1991; Ob-Gyn residency, University of Texas Southwestern Medical Center, Dallas, TX 1991-95; elected by West Mississippi Medical Society.

ENTRIKEN, WILLIAM F., Hattiesburg. Born Biloxi, MS, June 22, 1963; DO Chicago College of Osteopathic Medicine, Chicago, IL, 1991; interned one year Chicago Osteopathic Hospital, Chicago, IL; emergency medicine residency, same, 1992-95; elected by South MS Medical Society.

FLETCHER, MARK H., Tupelo. Born Gadsden, AL, December 24, 1961; MD University of Alabama School of Medicine, Birmingham, AL, 1988; neurology residency, Medical College of Georgia, Augusta, GA, 1989-92; elected by Northeast MS Medical Society.

HATTEN, MARGARET T., Jackson. Born Jackson, MS, June 13, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1991; radiology residency University Medical Center, Jackson, MS, 1991-94; fellowship in body imaging, same, 1994-95; elected by Central Medical Society.

JACKSON, TIM D., Gulfport. Born Lexington, KY, March 15, 1964; MD Indiana University School of Medicine, Indianapolis, IN, 1990; orthopaedic surgery residency, Emory University Medical Center, Atlanta, GA, 1990-95; elected by Coast Counties Medical Society.

JAGNANDAN, N. R. Born Guyena, South American, August 23, 1950; MD University of Mississippi School of Medicine, Jackson, MS, 1980; family practice residency, Tripler Army Medical Center, Honolulu, Hawaii; elected by Central Medical Society.

LAWRENCE, JESSE A., Southaven. Born Memphis, TN, January 25, 1934; MD University of Tennessee College of Medicine, Memphis, TN, 1960; neurology residency Mayo Clinic & Foundation, Rochester, MN 1968-71; elected by Desoto County Medical Society.

LEIS, A. ARTURO, Jackson. Born Detroit, MI, September 11, 1956; MD University of Arizona College of Medicine, Tucson, AZ, 1983; neurology residency, University of Texas at Houston Medical Center, Houston, TX, 1984-87; fellowship in neurophysiology, University of Iowa Medical Center, Iowa City, IA 1987-90; elected by Central Medical Society.

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LUBENSKY, JACK, Greenville. Born November 29, 1945; MD University of Southern California School of Medicine, Los Angeles, CA, 1971; urology residency, Brooke Army Medical Center, Brooke Army Medical Center, Fort Sam Houston, TX 1973-77; elected by Delta Medical Society.

McAULEY, JAMES R., Jackson. Born Memphis, TN, January 22, 1964; MD Univeristy of Mississippi School of Medicine, Jackson, MS, 1990; interned one year and otolarygology residency, University Medical Center, Jackson, MS, 1990-95; elected by Central Medical Society.

McGAUGH, RONALD C. JR., Meridian. Born September 17, 1963; MD University of Arkansas School of Medicine, Little Rock, AR, 1992; interned one year; elected by East MS Medical Society.

McINTOSH, COOPER A., Oxford. Born Memphis, TN, September 9, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1992; interned and internal medicine residency, University of Tennessee at Memphis Medical Center, Memphis, TN, 1992-95; elected by North MS Medical Society.

NEAL, F. LEE, JR., Brookhaven. Born Lincoln Co, MS, August 22, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family practice residency University of Alabama Medical Center East, Birmingham, AL, 1992-95; elected by South Central Medical Society.

NEVILLE, TINA F., Gulfport. Born Gulfport, MS, August 29, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; neurology residency, University of Mississippi Medical Center, Jackson, MS, 1990-94; neuromuscular fellowship, same, one year; elected by Coast Counties Medical Society.

OWENS, DAVID M., Vicksburg. Born Durant, OK, February 5, 1966; MD University of Texas Southwestern Medical School, Dallas, TX 1991; Ob-Gyn residency, University of Texas Southwestern Medical Center/Parkland Memorial Hospital, Dallas, TX, 1991-95; elected by West MS Medical Society.

RICHARDSON, RANDY K., Oxford. Born Fort Worth, TX, March 28, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1985; ophthalmology residency, University of Mississippi Medical Center, Jackson, MS, 1985-89; elected by North MS Medical Society.

RODGERS, DEBRA E., Jackson. Born May 6, 1950; MD Univeristy of Mississippi School of Medicine, Jackson, MS, 1977; psychiatry residency, University Medical Center, Jackson, MS, 1977-80; elected by Central Medical Society.

SANFORD, WILLIAM D., JR., Oxford. Born Marrero, LA, July 19, 1963; MD University of Tennessee College of Medicine, Memphis, TN, 1989; pediatric residency, Vanderbilt University School of Medicine, Nashville, TN, 1989-92; elected by North MS Medical Society.

SUNDARAM, MECHERI B., Jackson. Born India, December 25, 1949; MD Madras University, India 1973; internal medicine residency, New Castle, England 1974-76; neurology residency, Leeds University, England 1977-81; EEG/Epilepsy fellowship, University of W. Ontario, London Canada, 10/82 - 4/83; elected by Central Medical Society.

VINCENT, ROBERT DeWITT, JR., Jackson. Born Tampa, Fl, March 20, 1952; MD Louisiana State University School of Medicine, New Orleans, LA, 1982; interned one year Charity Hospital, New Orleans, LA; anesthesiology residency, Tulane Medical Cener, New Orleans, LA, 1982-95; fellowship in ob-gyn-anesthesia, University of Iowa Hospitals & Clinics, Iowa City, IA, 1989-90; elected by Central Medical Socicty.

REINSTATEMENTS:

JAMES H. CALANDRUCCIO, Southaven
A. M. CHIEMPRABHA, Mendenhall
ERIC M. DYESS, Meridian
TERI O. DYESS, Meridian
RUTH FREDERICKS, Jackson
TERRY M. FRENCH, Meridian
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Personals

Michael J. Borne, M.D., with Mississippi Retina Associates in Jackson, has recently given scientific papers on current vitreo-retinal surgical techniques for removing retained lens fragments at the Retina Society Meeting in Santa Fe, NM in September, 1995 and the annual meeting of The American Academy of Ophthalmology in Atlanta, GA in October, 1995. He also has had scientific papers accepted for publication in upcoming issues of The Journal of Ophthalmology and The Journal of Pediatric Ophthalmology and Strabismus.

Peter S. Kamp, M.D., and Diane M. Little, M.D., members of the Mississippi Psychiatric Society, participated in the APA *Practice Research Network (PRN) Study of Psychiatric Patients and Their Treatments.* The primary purpose of the pilot study was to learn more about psychiatric patients and the treatments they receive by collecting detailed patient-level data on clinical practice patterns. The study also pilot tested a simple method of systematically selecting patients and methods to facilitate the conduct of network studies.

J. Elmer Nix, M.D., was elevated to the Presidency of the Clinical Orthopaedic Society at its annual meeting in San Antonio, Texas, in early October. The Clinical Orthopaedic Society is a national invitational organization for orthopaedic surgeons and is the second oldest orthopaedic organization in the United States.

Alan E. Freeland, M.D., Professor of Orthopaedic Surgery at the University of Mississippi Medical Center in Jackson was the invited guest speaker for the 21st Annual Meeting of the Argentina Society for Surgery of the Hand and was warded honorary membership in the Society.

Paul M. Allen, M.D., a gynecologist and obstetrician practicing in Pascagoula, has co- authored an article entitled *The Female Urethral Syndrome is Rarely Associated with Human Papillomavirus Infection types 6/11,i6,18,31,33* which appeared in the September 1995 edition of the *International Urogynecology and Pelvic Floor Dysfunction Journal.* Dr. Allen is the Chief Executive Officer and Medical Director of Women's center for Health Care, an accredited single specialty ambulatory surgical center. He is also serving as Director of Continuing Medical Education at Singing River Hospital in Pascagoula.

Walter C. Gough, M.D., has completed the American Board of Family Practice Recertification Examination. He is recertified as a Diplomate until December 31, 2002.

John H. Eichhorn, M.D., chairman of anesthesiology became chairman of the Committee on Standards of Care of the 34,000-member American Society of Anesthesiologists during the society's annual meeting. Eichhorn has been a member of this committee since its inception in 1985 and has participated actively in establishing standards of practice especially concerning anesthesia safety.

Winfred Wiser, M.D., Professor of ob-gyn was honored at the 10th anniversary meeting of the Winfred L. Wiser Society. Members presented him with a booklet by former residents and faculty who wrote about their memories of training under and working with Wiser, who was department chairman from 1976-1995. Society members also made the official announcement of the establishment of the Winfred L. Wiser Chair in Gynecology which has already received substantial support from ob-gyn alums.

Blair E. Batson, M.D., professor emeritus of pediatrics at the University Medical Center and first chairman of the department, was one of five inductees in the Alumni Hall of Fame during homecoming activities on the Oxford campus. This is the highest honor bestowed by the University of Mississippi Alumni Association. Batson was chair of the department when the Center opened in 1955 until his retirement in 1989.

Angelos Halaris, M.D., chairman of psychiatry at the University Medical Center, presented a paper at the Society of Biological Psychiatry and American Psychiatric Association meeting.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

James N. Martin, Jr., M.D., director of the maternal-fetal medicine, was course director for the Postgraduate Course of the American College of Obstetricians and Gynecologists annual clinical meeting.

William C. Brawner, M.D. has become Board Certified in Ophthalmology by the American Board of Ophthalmology. Dr. Brawner has passed both the written examination and the oral examination. A native of Biggersville, he earned his bachelors degree at Ole Miss and received his medical degree from the University of Mississippi Medical Center. He completed four years of post-doctoral residency in Ophthalmology at the University Medical Center. Dr. Brawner is associated with Joseph J. Chappell, M.D., at the Tupelo Eye Center.



Boyd Shaw, M.D., *of Jackson, MS (right) was presented the Distinguished Service Award of the American Lung Association of Mississippi at their annual meeting in Jackson. Presenting the award to Dr. Shaw is* ***Dr. Roland B. Robertson, first vice president.***

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Children of the Singing River Medical Alliance went trick or treating among local physician offices for the Domestic Violence Shelter. The program was held in conjunction with the National Alliance's SAVE project. The Alliance members and their goblins collected their donations which raised more than $2,600 for the local shelter. Accepting a check from ***Bob Donald, III, M.D., are Whit Whitlock (Ninja); Benjamin Donald (Superman); Spencer Whitlock (Power Ranger); Morgan Avara (zebra); Bethany Whitlock (Snow White) and Madison Avara (witch).***

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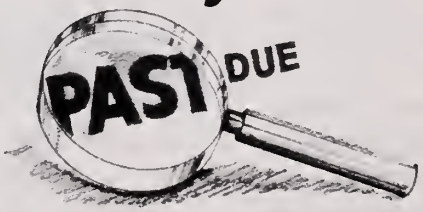
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Physicians' Recognition Award



Four MSMA members were named recipients of the AMA Physicians Recognition Award in November 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
James Douglas Fly, MD
Gilliam Swink Hicks, MD

East Mississippi Medical Society
Jimmy Eugene Isbell, MD

South Central Medical Society
Daniel Talmadge Keel, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Jennifer Corson at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE
Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

INSURANCE/FINANCIAL/RETIREMENT PROGRAM
MSMA members have available several insurance plans designed exclusively for physicians. Through the "group" buying power of the association the plans can usually be obtained at lower cost and there is the advantage of "one stop" coverage. For further information contact Executive Planning Group.

MEDICAL MALPRACTICE INSURANCE
The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. The Company currently has 2000 policy holders. Extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

AMA Purchase Link - 800-772-4346.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - P.O. Box 5229, Jackson, MS 39296-5229, 601-354-5433 or 800-898-0251 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-2000 or 800-325-4172 (In -State-WATS).

Executive Planning Group, P. A. - 601-982-3000 or 800-898-0954 (In-state-WATS).

Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

Key Words should follow the abstract and be identified as such. Provide three to five key

words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

References must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

Journals

[1] **Author(s).** Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] **Title of article.** Capitalize only the first letter of the first word. [3] **Name of Journal** followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] **Year of publication**; [5] **Volume number:** Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] **Inclusive page numbers.** Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol* 1979;71:680-692.

Books

[1] **Author(s).** Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] **Title**, Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less that four letters. [3] **Edition number,** [4] **Editor's name.** [5] **Place of publication,** [6] **Publisher,** [7] **Year,** [8] **Inclusive page numbers.** Do not omit digits.

Example: DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in Cardiovascular Medicine, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

Illustrations should be submitted in duplicate in an envelope (paper clips should not be used on illustrations since the indentation they make may show on reproduction). Legends should be typed, double-spaced on a separate sheet of paper. Photographic material should be high-contrast glossy prints. Patients must be unrecognizable in photographs unless specific written consent has been obtained, in which case a copy of the authorization should accompany the manuscript. All illustrations should be referred to in the body of the text. Omit illustrations which do not increase understanding of text. **Illustrations must be limited to a reasonable number** (four illustrations should be adequate for a manuscript of 4 to 5 typed pages.) The following information should be typed on a label and affixed to the back of each illustration: figure number, title of manuscript, name of senior author, and arrow indicating top.

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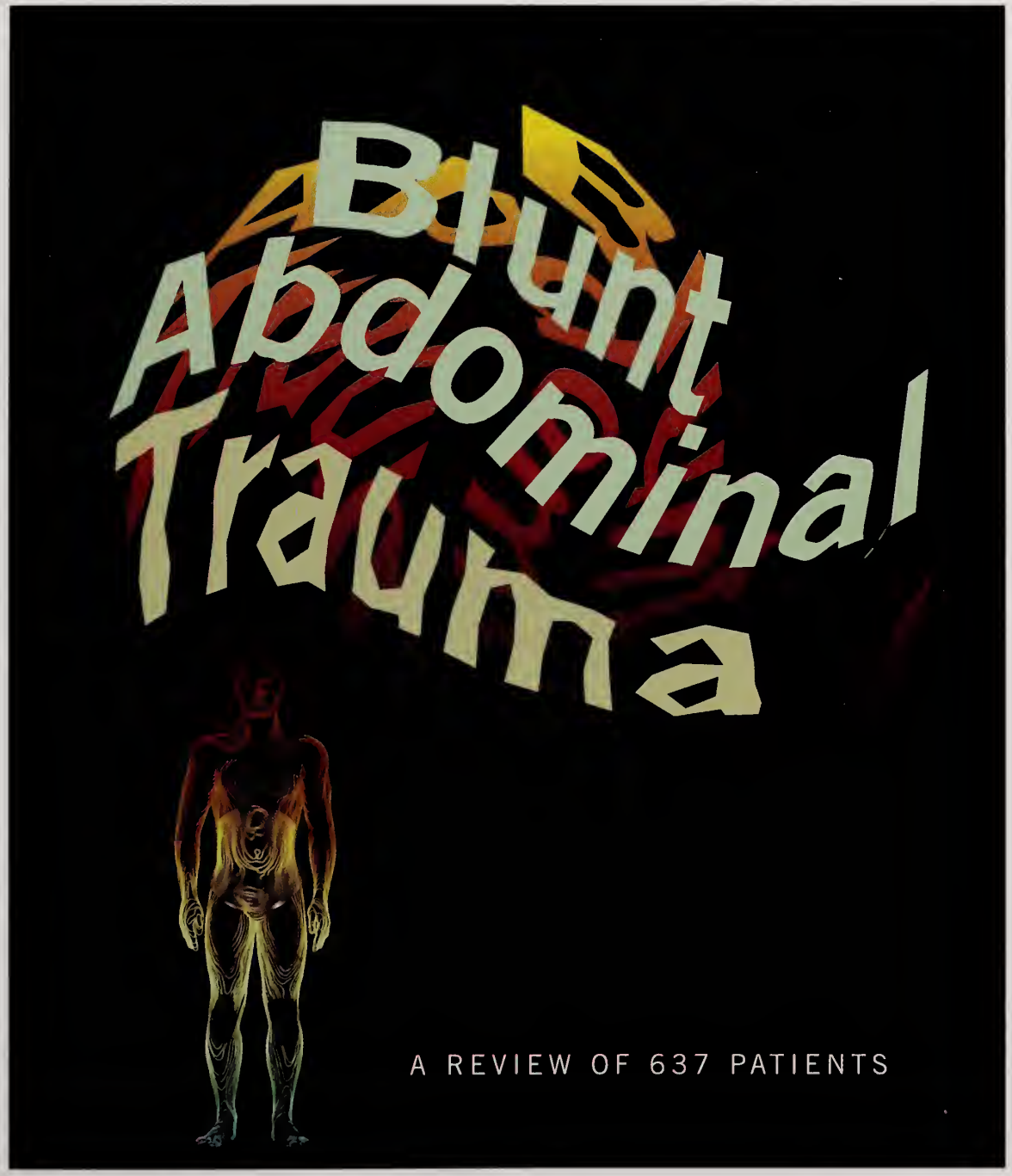
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Blunt Abdominal Trauma
A Review of 637 Patients

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Key Words: Blunt abdominal trauma,
Motor Vehicle accidents.

Abstract

Although blunt abdominal trauma continues to cause significant morbidity and mortality, the care of these patients has improved significantly over the past 30 years. In order to evaluate the current status of management, we have reviewed retrospectively the medical records of all such patients admitted to the University of Mississippi Medical Center over a ten- year period (October 1, 1981 - September 30, 1991). Of the total of 637 patients, 61 % were male and 39% female; 40% were between the ages of 20 and 29 years. Motor vehicle accidents accounted for approximately 80% of these injuries. Of the total, 399(62.6%) underwent laparotomy, 12 (3%) of which were nontherapeutic. The operative mortality rate was 13% and the overall mortality for the 637 patients was 8.5%.

These results are compared with four previous series of blunt abdominal trauma patients. Women comprised a greater proportion in the two most recent series. The liver and spleen are the most commonly injured intra-abdominal organs; however, liver injuries have been reported in increasing numbers of patients in the most recent series. The incidence of nontherapeutic laparotomy is less with each succeeding series. Mortality rates have declined significantly and the 8.5% mortality in our patients is certainly indicative of this trend.

Introduction

Significant advances have been made over the past 30 years in the care of the patient who has sustained blunt abdominal trauma (BAT). Emergency medical system networks have been established to shorten the interval

between injury and treatment and afford more patients an opportunity to receive expert medical care. Improved ventilatory assistance, invasive monitoring, anesthesia and pharmacologic support have influenced perioperative and nonoperative therapy.[1] Prior to 1965, evaluation of the patient with BAT consisted of physical examination, supplemented with plain roentgenograms and four-quadrant abdominal paracentesis. By the mid-1970s, however, diagnostic peritoneal ravage (DPL) had become a standard diagnostic aid. Computerized tomographic (CT) evaluation of trauma patients was added to the diagnostic armamentarium in the late 1970s. Research over the past decade has concentrated on comparing CT and DPL to determine which is superior for evaluating BAT. Although debate continues, a consensus is emerging that CT and DPL are complementary rather than exclusive procedures.[2,3]

The first report evaluating patients with BAT was that of Fitzgerald, Crawford, and DeBakey in 1960.[4] Two studies were reported from Charity Hospital in New Orleans (1968 and 1975).[5,6] The most recent large series was that from the Maryland Institute for Emergency Medical Services Systems in 1983.[7] Each of these reports had a similar patient cohort with regard to age, sex, mechanism of injury, and abdominal organs injured; however, non- therapeutic laparotomy and mortality rates declined over the 35-year period. In order to evaluate the current status of BAT management, the records of all such patients admitted to the University of Mississippi Medical Center during a 10-year period were examined retrospectively. Our findings and their comparison to those of the previous series form the basis of this report.

Materials and Methods

The medical records of all patients admitted to this Level I trauma center with blunt abdominal trauma between October 1,1981, and September 30, 1991, were reviewed retrospectively. A total of 637 patients were identified. Demographic data, method of injury, methods of diagnostic evaluation, abdominal organs injured, and outcome were assessed.

During this 10-year period. patients who were hemodynamically unstable underwent DPL or, if intra-abdominal injury was obvious, exploratory laparotomy. Patients who were hemodynamically stable but had an unreliable physical examination (such as in neurologic injury or intoxication) and patients who were to undergo emergency general anesthesia for an extra-abdominal injury (physical examination interrupted) underwent CT if certain criteria were met: (1) that CT would aid in evaluation of an extra-abdominal injury (e.g., spine, pelvis, or head); (2) that the patient had previous abdominal surgery; or (3) that retroperitoneal injury was suspected due to flank hematoma or hematuria. These patients otherwise underwent DPL. Decisions regarding therapy in stable patients with reliable physical examinations were made without CT or DPL.

Results

During this 10-year period, 637 patients were admitted with a diagnosis of BAT. The group was predominantly male (61%) and the mean age was 26.4 years; 40% were aged 20-29 years.(Table 1).

The method of injury is depicted in Table 2.(See right.) Motor vehicle accidents accounted for approximately 80% of these injuries.

In Table 3 (See right.) are shown the organs injured in this group of patients. Included in these numbers are injuries identified in 47 patients who were observed and did not undergo laparotomy. Of the total, 399 patients (62.6%) underwent laparotomy. Of these operations, 12 (3%) were nontherapeutic, so-called "negative laps" (Table 4) (See right.).

Table 1. Age of 637 Patients with Blunt Abdominal Trauma.

Age (in years)	Number of Patients
<1	1
1 - 9	49
10 - 19	142
20 - 29	254
30 - 39	108
40 - 49	50
50 - 59	16
60 - 69	9
70 - 79	6
80 - 89	2

Nontherapeutic laparotomy was defined as an operation in which resection, repair, or hemostasis was not performed. Mortality among these 399 patients undergoing emergency laparotomy for blunt trauma was 13%. The overall mortality was 8.5%.

Discussion

This group of BAT patients treated between 1981 and 1991 is compared in Table 5 with reported series from previous eras.[4,5,6,7] Not included for comparison are a large number of studies from the late 1980s and early 1990s that evaluated CT and DPL as diagnostic meth-

Table 2. Method of Injury in Blunt Abdominal Trauma.

Type	n	% of total (n = 637)
MVA	414	65.0
Fall	69	10.8
MVA - Pedestrian	43	6.8
Assault	40	6.3
Motorcycle or Bicycle	24	3.8
MVA - Cycle	11	1.7
Overturned tractor	5	
Boating accident	3	
Rolled over by a car or truck	3	
MVA - Train	2	
Child abuse	2	
Thrown from a bull/horse	2	
Tree fell on abdomen	2	
Tree fell on back	2	
Exploding tire (while changing)	2	
Car fell on patient	2	
Cycle - Pedestrian	1	
MVA - 3-wheeler	1	
Rolled over by a horse	1	
Kicked by animal	1	
Go-cart accident	1	
Hit by baseball	1	
Hit by 2"x4" piece of lumber	1	
Football injury	1	
MVA - Wheelchair	1	
Stepped on by a cow	1	
Unknown	1	

MVA = Motor Vehicle Accident

Table 3. Most Common Injuries in Blunt Abdominal Trauma.

Injuries Identified at Laparotomy	n	% of total (n = 637)	% of total operated on (n = 399)
Liver	175	27.7	43.9
Spleen	158	24.8	39.6
Small Intestine Duodenum 12 Jejunum 11 Ileum 7 Not specified 20	50	7.8	12.5
Mesenteric Rent	48	7.5	12
Kidney	47	7.4	11.8
Pancreas	19	3	4.8
Diapbragm Rent Left only 16 Right only 2 Bilateral 1	19	3	4.8
Colon	15	2.4	3.8
Bladder	12	1.9	3
Gallbladder	8	1.3	2
Stomach	3	0.5	0.7
CT Findings in 45 Patients NOT Operated On			
Injury	n		
Spleen	22		
Kidney	18		
Liver	11		
Free Fluid	2		
Right Psoas Hematoma	1		
Ultrasound Findings in 2 Patients NOT Operated on			
Injury	n		
Splenic Hematoma	2		

Table 4. Indications for Operation in 12 Patients with Nontherapeutic Laparotomies.

Negative Laparotomy	
Indication	n
Unknown	7
Shock	2
Acute Abdomen	1
Tender Abdomen	1
Gravid and Tender Abdomen	1
TOTAL	12 (3%)

ods. In these studies CT was reserved for stable patients, thereby excluding unstable blunt trauma patients.

In 1960, Fitzgerald, Crawford, and DeBakey[4] retrospectively reviewed the medical records of 100 consecutive patients treated at Jefferson Davis Hospital in Houston for non-penetrating abdominal trauma and compared them with 100 consecutive autopsy records of patients who suffered BAT and were dead on arrival. The lethal nature of BAT injuries at that time is indicated by the difference in time periods required to obtain the case numbers. A period of 101/2 years (January 1948 to July 1958) was required in order to amass a total of 100 consecutive patients who arrived at the hospital alive, while a review of only two years and seven months (January 1954 to August 1957) produced 100 consecutive patients who were dead on arrival. The data regarding organs injured reflect injuries identified at operation; all 100 patients who arrived alive underwent exploratory laparotomy. Although nontherapeutic laparotomies are mentioned, the actual number is not given. Diagnostic evaluation during this era relied heavily on physical examination; diagnostic paracentesis was performed in ten patients, with a 40% incidence of false negative results.

In 1968, Di Vincenti et al.[5] reported the Charity Hospital in New Orleans experience with BAT from January 1951 through December 1966. A total of 518 patients were included in the study and laparotomy was performed in 359. Four-quadrant paracentesis was described as "the most valuable single diagnostic procedure."(page 1008) The number of nontherapeutic laparotomies was not reported.

An update of the Charity Hospital series was published in 1975 [6], including all BAT patients from January 1967 through December 1973. The records of 437 patients were reviewed; 269 of these patients underwent laparotomy. Although DPL was used in a small number of these cases, four-quadrant paracentesis remained the most common diagnostic aid during this interval.

In 1983, Cox[7] published a retrospective review of 870 patients undergoing laparotomy for blunt trauma at the Maryland Institute for Emergency Medical Services in Baltimore from January 1978 through December 1982. The criteria for exploratory laparotomy were "based exclusively on diagnostic peritoneal lavage."(page 471)

Attempts to compare retrospective studies from different institutions over varied periods of time are fraught with potential misinterpretation. Nevertheless, certain trends may be inferred from the data in Table 5. Women comprised a greater proportion of the two most recent series, while the mean age has remained fairly constant. Motor vehicle accidents have continued to cause the vast majority of BAT. The spleen and liver are clearly the most commonly injured intra-abdominal organs in BAT; however, liver injuries have been identified in increasing numbers of patients in the most recent reports. This trend is consistent with the subjective impression of some authors [8,9] and may represent the increased sensitivity of DPL and CT over physical examination and four-quadrant paracentesis. The incidence of nontherapeutic laparotomy declines with each succeeding series.

Table 5. Series of BAT Patients

Source	Age	Sex	Method of Injury	Organs Injured	Percent Requiring Laparotomy	Non-therapeutic Laparotomy	Oper. Mort.	Overall Mort.
Fitzgerald, Crawford, DeBakey 1948-1958 100 patients	53% aged 21-50 years	M = 73% F = 27%	MVA = 83% Blow to Abd = 6.5% Fall = 5.0%	Liver = 31% Spleen = 51% Bowel = 15% Mesentery = 8% Kidney = 4.5% Diaphragm = 8%			33%	
Di Vincenti, et al. 1951-1966 518 patients		M = 76% F = 24%	MVA = 74% Blow to Abd = 17% Fall = 9.2%	Liver = 24% Spleen = 62% Bowel = 12% Mesentery = ? Kidney = 6.5% Diaphragm = 2.2%	69%		14%	23%
Davis, et al. 1967-1973 437 patients	24% aged 21-30 years	M = 70% F = 30%	MVA = 70% Blow to Abd = 17% Fall = 6%	Liver = 26.8% Spleen = 40.1% Bowel = 24.9% Mesentery = 5.6% Kidney = 11.2% Diaphragm = 2.2%	62%	14.9%	14.8%	13%
Cox, 1978-1982 870 patients	Avg. age 29.7 years	M = 63% F = 37%	MVA = 90%	Liver = 35.6% Spleen = 42.0% Bowel = 4.7% Mesentery = 13.0% Kidney = 2.7% Diaphragm = 5.3%		10.2%	25%	
Ball, Croley, 1981-1991 637 patients	40% aged 20-29 years	M = 61% F = 39%	MVA = 80% Blow to Abd = 8.3% Fall = 10.8%	Liver = 43.9% Spleen = 39.6% Bowel = 16.3% Mesentery = 12.0% Kidney = 11.8% Diaphragm = 4.8%	62.6%	3%	13%	8.5%

Mortality rates are particularly difficult to compare. A number of variables, including the proximity of the accident to the institution and the speed of pre-hospital transport, are certain to affect operative and nonoperative mortality rates and may explain the higher operative mortality reported by Cox. However, in that series the operative mortality declined from 30% in 1978 to 16.6% in 1982. The 8.5% mortality in 637 BAT patients in our series is certainly an improvement over previously reported figures, reflecting continued improvement in the evaluation and treatment of patients with BAT.

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Phenytoin Hypersensitivity Syndrome

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Key Words: Phenytoin
Hypersensitivity
Anti convulsants

Abstract

The purpose of the current manuscript is to familiarize the primary physician with the presentation of phenytoin hypersensitivity syndrome, and to discuss management options.

A review of all admissions to the University of Mississippi Medical Center over a five year period revealed 4 cases of phenytoin hypersensitivity syndrome. These cases are presented and the phenytoin hypersensitivity syndrome, characterized most commonly by fever, cutaneous eruption and lymphadenopathy, is described. It is emphasized that the clinician must be aware of the syndrome and must recognize it on presentation. Theories regarding etiology and treatment options are discussed. It is recommended that all patients with symptoms of phenytoin hypersensitivity syndrome be hospitalized and that steroids be initiated.

Phenytoin Hypersensitivity Syndrome

The commonly used anticonvulsant, phenytoin (diphenylhydantoin), was first used to treat seizure disorders in 1938', and a phenytoin hypersensitivity syndrome was described in 1950.[2,3] More than 100 cases have been reported since then.[4,5] The typical syndrome consists of fever, rash, lymphadenopathy and hepatitis.[2,4,6,7] Other manifestations may include interstitial pulmonary infiltrates, anemia, thrombocytopenia, eosinophilia, interstitial nephritis, and diffuse intravascular coagulopathy.[1,2] Although the incidence of mild hypersensitivity involving a maculopapular rash may be as high as 2-17%,[4] the full-blown syndrome is rare.

A review of all admissions to the University of

Mississippi Medical Center in the period from January, 1987, to March, 1992, revealed four cases of phenytoin hypersensitivity syndrome.

The purpose of the present paper is to present these four cases, and to review the recent literature. Since the symptoms of the phenytoin hypersensitivity syndrome, fever, cutaneous eruption and lymphadenopathy, may be easily attributed to an infectious process, it is important for the primary physician to be aware-of the syndrome, and to recognize it on presentation. Possible etiologies are discussed and treatment options are presented.

Cases

Case 1

A 15 year old African-American male with a two-year history of post-traumatic generalized seizure disorder presented to the Emergency Department (ED) complaining of a generalized pruritic rash. His seizures had initially been treated with valproic acid, but his medication had been changed to phenytoin two weeks earlier. On arrival in the ED, he was found to have a temperature of 101.2° F with other vital signs within normal limits. Physical examination was remarkable for an erythematous, maculopapular rash over his head, face, back, chest, and arms. The rash was felt to be secondary to phenytoin, so the phenytoin was discontinued and valproic acid was re-started. A phenytoin level was not checked. Steroids were not initiated at this presentation.

He returned 6 days later complaining of abdominal and back pain. His temperature was 103.1° F, pulse 108/min, respirations 24/min and blood pressure 110/70 mm Hg. The rash was still present. The patient also had enlarged tender anterior and posterior cervical nodes, an enlarged liver extending 3 cm below the costal margin, and diffuse abdominal tenderness.

Admission laboratory included a complete blood count (CBC) and electrolytes that were unremarkable. Transaminases were elevated with SGGT 207 IU/L (normal range: 0.0-39 IU/L), SGPT 88 IU/L (normal range 2-50 IU/L) and SGOT 172 IU/L (normal range 1155 IU/L). Bilirubin was not elevated.

He was admitted and treated with IV antibiotics. A monospot test and hepatitis screen were negative. Transaminases, prothrombin (PT), partial thromboplastin (PTT) times, and bilirubin continued to increase. On hospital day 8 he was transferred to the pediatric intensive care unit and IV corticosteroids were initiated. He responded well to the steroids, until they were inadvertently stopped on hospital day 12. The patient became febrile again, the rash worsened, and transaminases again increased. Maximum values were SGGT 1304 IU/L, SGPT 668 IU/L, and SGOT 267 IU/L. High-dose steroids were restarted on hospital day 14, the patient had an immediate favorable response, and continued to improve as steroids were gradually tapered.

At discharge on hospital day 23, his transaminases were improved (SGGT 418 IU/L, SGPT 87 IU/L and SGOT 33 IU/L), and PT and PTT were normal. He was afebrile, and his rash had largely resolved. He was discharged on oral steroids with a followup appointment in the Pediatric Neurology clinic in 2 months.

Case 2

A previously healthy 16-year-old African-American male was started on phenytoin and hydralazine after presenting with a new onset generalized seizure. At that time he was found to be in renal failure with hypertension, felt to be secondary to glomerulonephritis.

Seventeen days after initiation of his medications, he presented to the University Medical Center with complaints of pruritic rash and fever for 24 hours. His temperature was 100.9° F, and other vital signs were unremarkable. Physical examination revealed a generalized maculopapular eruption. Admission laboratory was unremarkable except for increased BUN and creatinine consistent with his renal disease.

His phenytoin and hydralazine were discontinued. However, he continued to have daily fevers to 105° and 106° F, and the rash became confluent over his entire body. IV antibiotics were initiated but the patient remained febrile. Monospot, CMV titers, EBV titers, RPR, hepatitis screen and multiple cultures were negative. IV antibiotics were discontinued after 4 days, and over the 7 day hospital course, fever decreased and the rash improved to the point that the patient was discharged home.

He was readmitted 5 days later due to continuing fever and backache. On physical examination, he was found to have generalized lymphadenopathy and a fine desquamating rash over his arms, shoulders, trunk and legs. Transaminases were elevated with SGGT 514 IU/L, SGPT 469 IU/L and SGOT 316 IU/L. Total bilirubin was 5.7 mg/dl (normal range: .3-1.4 mg/dl) with direct bilirubin 4.7 mg/dl (normal range: 0.0-0.5 mg/dl). Multiple cultures were negative, as were hepatitis serologies. Computerized tomography of his abdomen demonstrated lymphadenopathy, and enlarged liver and spleen without mass or obstruction. Two bone marrow biopsies and a lymph node biopsy were negative. He defervesced during the hospitalization, and was discharged after 13 days. Steroids were not given.

Case 3

A 53 year old African-American female presented to the ED with a new onset generalized seizure which was treated with diazepam and phenytoin. Computerized tomography of her brain revealed a mass in the frontal region which was resected and found to be a spheroid meningioma. Thirty-three days later she presented to the ED with a two day history of a pruritic rash on her trunk, back and arms. She denied fever or chills. On examination, her temperature was 99.4° F, pulse 120/min, respirations 20/min and blood pressure 144/85 mm Hg. She had an erythematous maculopapular rash on her chest, neck, and upper arms with some areas of confluence. No adenopathy or hepatomegaly were noted. Complete blood count and electrolytes were unremarkable. Transaminases were elevated with SGGT 819 IU/L, SGPT 235 IU/L and SGOT 176 IU/L. Bilirubin was not elevated. Phenytoin hypersensitivity was diagnosed and phenytoin was discontinued. High dose intravenous steroids were initiated in the ED. Multiple cultures were negative, as was a hepatitis screen.

Intravenous steroids were continued for 3 days in the hospital. The patient showed rapid improvement and was subsequently discharged on a tapering dose of oral steroids.

Case 4

A 20 year old African-American female, 2 weeks postpartum, presented to the ED with one episode of generalized seizure activity. Her pregnancy had been complicated by pregnancy induced hypertension without eclampsia. Computerized tomography of the brain was unremarkable, and physical examination and laboratory were within normal limits. She was loaded with phenytoin in the ED and scheduled for outpatient neurological workup.

She returned to the ED 29 days later complaining of 3 days of a pruritic rash and fever. Her temperature was 101.9° F. She denied any other symptoms. She was given diphenhydramine in the ED and discharged on diphenhydramine and acetaminophen. She returned one day later with worsening symptoms. Her vital signs were: temperature 104.4° F, pulse 131/min, respirations 24/min and blood pressure 102/43 mm Hg. On physical examination she was noted to have a diffuse maculopapular rash involving her face, neck, trunk and extremities. She had diffuse lymphadenopathy, and right upper quadrant tenderness. Complete blood count and electrolytes were within normal limits, and transaminases were elevated with SGGT 187 IU/L, SGPT 75 IU/L and SGOT 126 IU/L. Bilirubin was not elevated. She was felt to have phenytoin hypersensitivity syndrome. Steroids were initiated in the ED, and phenytoin was discontinued.

She had a complicated 3 week hospital course with daily temperatures of 105° to 106° F, and worsening liver function tests. She was transferred to the medical intensive care unit on the third hospital day for closer monitoring, and she remained there for three days. Multiple cultures were negative, and intravenous antibiotics had no effect on her condition. However, the rash gradually improved, her fever decreased, and liver function tests improved. She did suffer one further exacerbation following a rapid decrease in her corticosteroid dose. When her steroid dose was increased and tapered more gradually, her symptoms improved, and she was discharged on tapering oral steroids.

Discussion

The phenytoin hypersensitivity syndrome typically develops within 1 week to 3 months after initiation of therapy, with most cases occurring within the first 3 weeks[1,4] As evidenced by the above cases, the most common presenting symptoms are cutaneous eruption and fever.[1,6] Fevers are typically high, in the 104°-105° F range.[2] Dermatologic manifestations include patchy erythema, Stevens-Johnson syndrome, erythema multiforme, and toxic epidermal necrolysis (TEN) .[1,2] TEN has the gravest prognosis with a reported mortality of up to 22%.[2,8] The rash often includes the oropharynx, may extend to the conjunctivae, and desquamates as it resolves. Generalized or localized edema, often involving the face, may be present.[1]

Hepatomegaly is a common finding and may be accompanied by splenomegaly.[1,9,10] Transaminases are commonly elevated, and although the bilirubin may be normal at presentation, hyperbilirubinemia can develop, even after phenytoin is discontinued. The importance of phenytoin hepatitis is that severe hepatitis is a poor prognostic factor with a reported overall mortality of 18%[1]. All of the cases reported here had evidence of phenytoin hepatitis. Of the four discussed cases, 3 had lymphadenopathy. Lymphadenopathy may be localized or generalized.[9] Biopsy of a node usually reveals benign lymphoid hyperplasia, however pseudolymphoma may be diagnosed with lymph node histology revealing atypical hyperplasia suggestive of malignancy[1,2] Both benign hyperplasia and pseudolymphoma resolve with discontinuation of phenytoin.[2,4] There have been rare reports of pseudo-pseudo lymphoma in which the patient developed lymphoma at a later date,[2,4,11] so close follow-up is recommended.

Other, less common manifestations include interstitial pulmonary infiltrates, acute renal failure, disseminated intravascular coagulopathy, anemia, thrombocytopenia, leukocytosis, eosinophilia, and atypical lymphocytosis.

There is a poor correlation between phenytoin levels and symptoms.[2,6] Onset of symptoms may be delayed, so that deterioration occurs several days after discontinuation of the drug,[2,4,9,10,12] as demonstrated by the first case. It is possible that non-compliance with medication may cause some patients to present with the syndrome more than a year after initiation of phenytoin.

Etiology

The mechanism of phenytoin hypersensitivity is undetermined. The three major theories involve antigen-antibody reaction, lymphocyte stimulation, and toxic metabolites. The antigen-antibody theory proposes that phenytoin acts as an antigen or a hapten resulting in antibody production. However, the presence of circulating phenytoin antibodies has not been consistently demonstrated. An IgG antibody has been identified by immunoelectrophoresis, but has not been present in all cases. At this time the correlation between the IgG antibody and the hypersensitivity syndrome remains controversial.[2,4,13]

The second theory postulates phenytoin stimulates lymphocyte proliferation and division. This theory is supported by increased incidence of atypical lymphocytes and lymphoid hyperplasia in phenytoin hypersensitivity syndrome. However, this has been studied in only a few patients with a lymphoid reaction and may not be the case with all patients exhibiting the syndrome.[2,4]

The third theory suggests a toxic metabolite of phenytoin, an arene oxide, is produced during oxidation of phenytoin by the cytochrome P-450 system. The metabolite may be directly cytotoxic or behave as a hapten in an immune reaction. Hypersensitivity is produced only in patients who have a metabolic defect that prevents them from detoxifying arene oxides. This theory could not only explain why the syndrome occurs only in some patients but also explain worsening symptoms in patients with decreasing phenytoin levels.[2,4] This theory also explains the occurrence of the syndrome in patients taking phenobarbital or carbamazepine, since both of these medications are also metabolized to arene oxides. Valproic acid is metabolized by a different pathway, and may be tolerated in individuals who develop hypersensitivity to phenytoin, phenobarbital or carbamazepine.[19,20,21]

Groups that are most likely to have phenytoin hypersensitivity are patients with a previous history of hypersensitivity who are re-exposed, patients who demonstrate an unrecognized hypersensitivity reaction but continue to receive therapy, and African-Americans.[10]

Treatment

The most important step in treatment is recognition of phenytoin hypersensitivity. When it is diagnosed, phenytoin must be immediately discontinued. The choice of an alternative anticonvulsant is complicated by reports of cross-reactivity with phenobarbital and carbamazepine, so phenobarbital, primidone and carbamazepine must be substituted with care, if at all.[4,5,6,14,19,20,21] Further, the patient must be carefully instructed regarding his hypersensitivity, since re-challenge, even in milligram amounts, can provoke a reaction.[1,2]

Although a controlled study has never demonstrated efficacy of corticosteroids in treatment of the syndrome, anecdotal reports support their use.[2,16,17,18]

It should be noted that two of the patients described above had worsening symptoms with accidental discontinuation or too rapid tapering of corticosteroids. No adverse effects of steroids were noted in our small sample.

It should be further noted that the initial presentation may be so mild as to lull the practitioner into a false sense of security. As demonstrated by the cases presented, the patient's condition may deteriorate despite discontinuation of the phenytoin, and the patient may become quite ill within a matter of days. Our results confirm the recommendation that all patients with the syndrome should be hospitalized.

The mainstay of treatment is supportive care until the syndrome resolves.

Summary

The phenytoin hypersensitivity syndrome, characterized most commonly by fever, cutaneous eruption, lymphadenopathy and hepatitis, was described, and four representative cases were presented. The most important task for the clinician is to recognize the syndrome when a patient presents with these symptoms, to discontinue phenytoin immediately and to provide adequate supportive care, including mandatory hospitalization. Corticosteroids are useful in amelioration of the symptoms. In our small sample, no adverse effects were noted with steroid therapy and symptoms worsened with too rapid tapering. Further case reports should be collected to clarify the beneficial or harmful effects of steroids in these patients.

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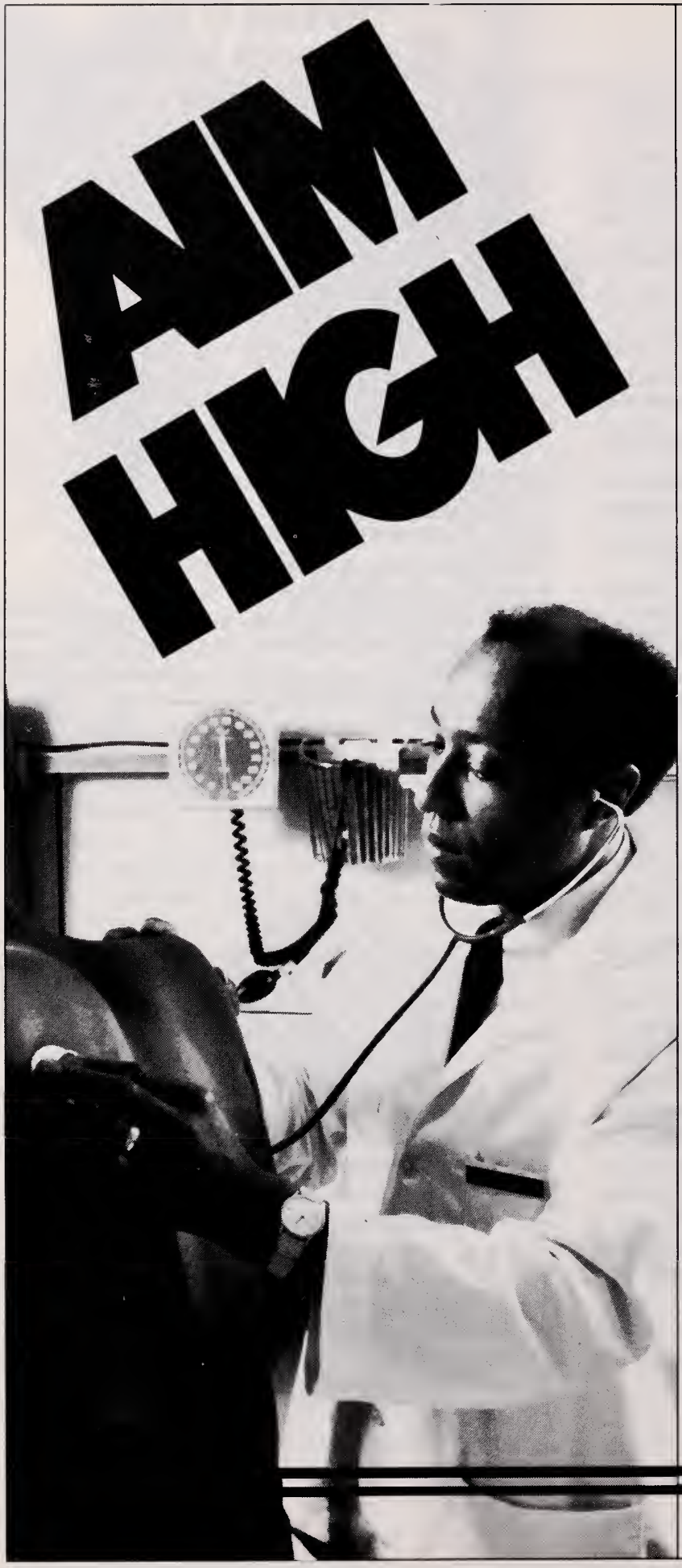
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The President's Page

Back to the Future

The computerized voice from the viewscreen on your bedside table signals the start of another day. Your electronic office reports your daily duties, based first on clinical priorities and then your management efficiency index. Most of your workday, less than half of which requires you to be physically present in the multidisciplinary clinic where you are employed, involves managing information.

Your first e-mail from a patient transmits clinical data from his home testing plus his dietary intake report and exercise log, and you congratulate him on his compliance and improvement. After further general recommendations, you remind him that by logging on his genotypical and demographic characteristics, he can get a personalized version on the HealthNet.

Welcome to medicine in the new millennium, circa 2010. Lest you think this is flight of fancy, the Institute of Alternative Futures (IAF), Alexandria, Virginia, is confident that in 15 years physicians will be mainly "health coaches," focusing on predicting and preventing disease. The days of treatment and managment of acute care symptoms will mostly be a thing of the past.

"There is going to be a lot of stress on physicians who hold expectations about maintaining a certain job role and level of income. The economic model will be no longer be on presentation of acute care symptoms driving interactions. If they want to make more money, that may be difficult. If they want a high level of autonomy, they will be challenged," says IAF Head Clement Bezold, PhD.

Technology will make this new world view possible as in-home information systems enable consumers to manage their own diagnoses and treatments for most non-acute conditions. Under this scenario, healthcare's portion of the GNP will be cut to 10% by 2010, and the bottom line would be powerful: Placing responsibility on the individual for health and managing healthcare expenditures could lead to better health and to improved and more cost-effective care.

For all the change that the future holds, there's a commitment to medicine or physicians that transcends time: The basic desire to help individuals. And from a personal perspective, with my patients' expectations of twice daily hospital rounds by a live physician and my returning personally every telephone message, it is difficult for me to envision a time when "bedside manner" would be replaced by "computer-side manner".

Despite the fact that I may not recognize the practice of medicine in 2010, I would like to think that what I'm about--and what you're about--on behalf of organized medicine will make a difference down the road for that generation of physicians.

Stanley

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Editorial

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SCIENCE TEST

[Editors Note: We wish to acknowledge and thank the Pathology Discussion Group On-Line (Internet) Patho-L@EMUVM1.cc, Emory, EDU for the following article.]

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Sometimes both truth and beauty come from the mouth of a child, and then again sometimes not. While this is not particularly germane to any current discussions on the list, I thought all us professionals could use a bit of a chuckle. Here are some interesting interpretations of nature from test papers and essays submitted to science and health teachers by junior high, school, and college students around the world.

"When you breath, you inspire. When you do not breath, you expire."

"H20 is hot water, and C02 is cold water."

"To collect fumes of sulphur, hold a deacon over a flame in a test tube."

"When you smell an odorless gas, it is probably carbon monoxide"

"Water is composed of two gins, Oxygin and Hydrogin. Oxygin is pure gin. Hydrogin is gin and water."

"Three kinds of blood vessels are arteries, vanes and caterpillars."

"Blood flows down one leg and up the other."

"Respiration is composed of two acts, first inspiration, and then expectoration."

"The moon is a planet just like the earth, only it is even deader."

"Artifical insemination is when the farmer does it to the cow instead of the bull."

"Dew is formed on leaves when the sun shines down on them and makes them perspire."

"A supersaturated solution is one that holds more than it can hold."

"Mushrooms always grow in damp places and so they look like umbrellas."

"The body consists of three parts--the brainium, the borax and the abominable cavity. The brainium contains the brain, the borax contains the heart and lungs, and the abominable cavity contains the bowels, of which there are five - a, e, i, o, and u."

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

"The pistol of a flower is its only protection against insects."

"The alimentary canal is located in the northern part of Indiana."

"The skeleton is what is left after the insides have been taken out and the outsides have been taken off. The purpose of the skeleton is something to hitch meat to."

"A permanent set of teeth consists of eight canines, eight cuspids, two molars, and eight cuspidors."

"The tides are a fight between the Earth and moon. All water tends towards the moon, because there is no water in the moon, and nature abhors a vacuum. I forget where the sun joins in this fight."

"A fossil is an extinct animal. The older it is, the more extinct it is."

"Equator: A menagerie lion running around the Earth through Africa."

"Germinate: To become a naturalized German."

"Liter: A nest of young puppies."

"Magnet: Something you find crawling all over a dead cat."

"Momentum: What you give a person when they are going away."

"Planet: A body of Earth surrounded by sky."

"Rhubarb: A kind of celery gone bloodshot."

"Vacuum: A large, empty space where the pope lives."

"Before giving a blood transfusion, find out if the blood is affirmative or negative."

"To remove dust from the eye, pull the eye down over the nose."

"For a nosebleed: Put the nose much lower then the body until the heart stops."

"For drowning: Climb on top of the person and move up and down to make artificial respiration."

"For fainting: Rub the person's chest or, if a lady, rub her arm above the hand instead. Or put the head between the knees of the nearest medical doctor."

"For dog bite: Put the dog away for several days. If he has not recovered, then kill it."

"For asphyxiation: Apply artificial respiration until the patient is dead."

"For head cold: Use an agonizer to spray the nose until it drops in your throat."

"To keep milk from turning sour: Keep it in the cow."

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Use of Ace Inhibitors in the Treatment of Heart Failure

A MISSISSIPPI CLINICAL IMPROVEMENT PROJECT

Background:

June, 1994 - the Agency for Health Care Policy and Research published a clinical practice guideline recommending early assessment of left ventricular function (LVF) and the use of ACE inhibitors in eligible patients.

Heart failure is the number one DRG for hospitalized Medicare patients in Mississippi and is often costly.

Studies have shown that using ACE inhibitors in both symptomatic and asymptomatic heart failure patients with reduced LVF can reduce morbidity and mortality.

Purpose:

Establish baseline data on use of ACE inhibitors at discharge in treatment of heart failure.

Establish baseline data on documentation of objective evaluation of LVF in Medicare patients admitted for treatment of heart failure.

Improve use of ACE inhibitors and documentation of objective evaluation of LVF in treatment of heart failure.

Methodology:

Foundation abstraction tool collected information on documentation of assessment of LVF and ACE inhibitor use in Medicare admissions for heart failure.

Findings:

Project data collection revealed 42.6% of patients were not discharged on ACE inhibitors.

The percentage of patients discharged on ACE inhibitors was similar in both bedsize categories (< 100 beds and > 100 beds).

Of the patients discharged on ACE inhibitors, larger hospitals documented LVF evaluation 73.5% of the time vs. 28.4% in the smaller hospitals.

Documentation of the numerical value of the LV ejection fraction also occurred less in smaller hospitals compared to larger hospitals.

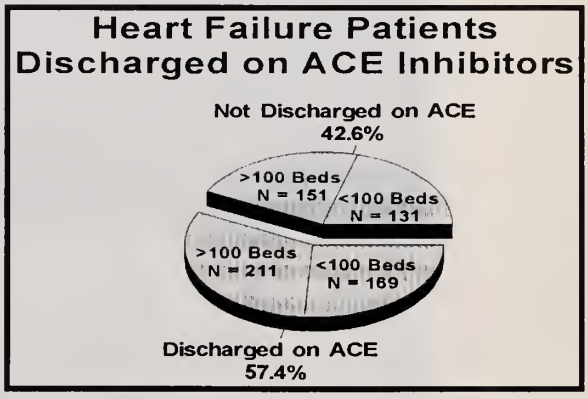
Of heart failure patients with a LV ejection fraction > 45% who were discharged on ACE inhibitors, 60% in smaller hospitals compared to 72.2% in larger hospitals had a diagnosis of hypertension.

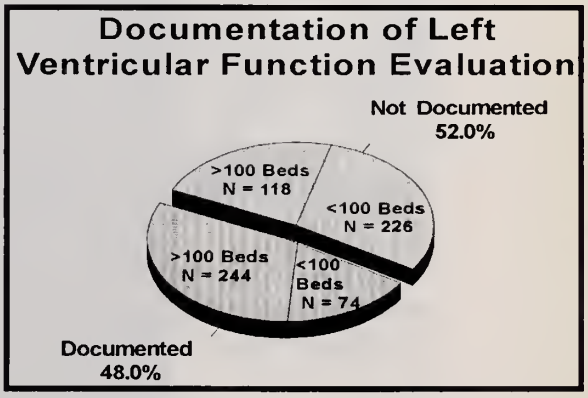
Conclusions:

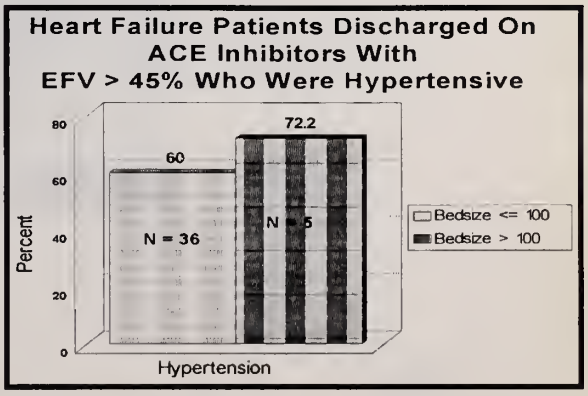
Opportunities for improvement were demonstrated.

Foundation shared findings with providers in April 1995.

Educational video is available through the Foundation.







FOUNDATION FOR MEDICAL CARE

FOR MORE INFORMATION, CONTACT:

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West Mississippi Medical Society President Dr. Charles A. Marascalco *introduced* ***MSMA President Dr. D. Stanley Hartness*** *when he adressed the group January 9, 1995.*



The ***West Mississippi Medical Society*** *met at Maxwell's restaurant in Vicksburg to hear* ***MSMA President Dr. D. Stanley Hartness*** *speak.*



***MSMA Director of Government Affairs Charmain Thompson** talks with **MSMA Vice Speaker of the House Dr. George E. McGee** of Hattiesburg at the MSMA and the Mississippi Hospital & Physician's 1996 Joint Legislative Forum held at the Ramada Inn, downtown Jackson, January 16, 1996. Charmain gave a Review of Mississippi Health Care Legislative Issues to registrants. **Dr. John F. Lucas** of Greenwood is seated middle.*



***Charlie Cook**, one of the nation's most respected election analyst of American elections and politics and a columnist for Capitol Hill's newspaper **Roll Call** presented " An Insiders View" at the Joint Legislative Forum luncheon.*



***Dr. Charles Garfield** of San Francisco, California, author of **Peak Performers:The New Heroes of American Business** and **Second to None** spoke on management and leadership issues at the Forum.*

CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XI

Differential Diagnosis: Rathel L. Nolan, III, M.D.
Radiological Diagnosis: Rachel S. Surrett, M.D.
Jennifer Hamrick-Turner, M.D.
Pathological Diagnosis: Amy R. Hudson, M.D.
Kay G. Allen, M.D.
Selection and Preperation: Richard D. Guynes, M.D., Roger L. Huey, M.D., Michael R. McMullan, M.D.

CASE PRESENTATION

A 50 year old black male was first seen in the University of Mississippi Medical Center Emergency Department on May 9, 1994, with complaints of nonproductive cough, fever to 101 F, and chills for five days. Physical exam and a chest radiograph revealed a right lower lobe infiltrate. The patient received one gram of Ceftriaxone I.V., and was sent home on Penicillin 500mg q.i.d. and Lorabid 200mg b.i.d. with instructions to follow up in the Medicine clinic. The patient complied with therapy and on return on May 23 to the Medicine clinic noted improvement in cough but persistent subjective fever. His oral antibiotics were renewed.

On June 11, 1994, the patient returned to the Emergency Room with increasing sputum, cough, and dyspnea on exertion. He denied fevers or chills during the previous week. The patient had some nausea but denied vomiting, night sweats, exposure to tuberculosis, or ill contacts. He reported a 20 pound weight loss over the last nine months. He had not had alcohol since the onset of symptoms in May, and he reported no recent travel outside the southeastern United States. He was admitted with a diagnosis of unresolved pneumonia.

Past medical history was positive for alcohol use and possible COPD. He had no past surgical history. Medications include over the counter cold remedy, castor oil. He had no known allergies. His review of systems was noncontributory.

His social history includes alcohol, one pint of beer plus one fifth of wine daily. He had smoked one pack of tobacco daily for 30 years. His sexual history was with "one steady lady" and no homosexual activity.

His physical exam on presentation included a temperature of 100.5, pulse of 102, respiration of 18, and blood pressure of 118/66. He was a well developed, well nourished black male in no acute distress. He was alert and oriented x 3. His HEENT was normal. Neck exam revealed no adenopathy. Cardiovascular was unremarkable. Lung exam revealed decreased breath sounds in the right base, inspiratory rales and egophony was noted. His abdomen showed his liver to be 12cm, no spleen was felt, and was otherwise unremarkable. His extremity, neurological, and skin were unremarkable with no rash seen. His GU was normal with no discharge or lesions.

Laboratory data when he presented included a white count of 11,800 with 35% segs, 32 bands, and 11 lymphs. His hemoglobin and hematocrit of 10gms and 31% were normal. He had an MCV of 92 and an RDW of 17. His platelets were 537,000. His chem 7 and 15 were remarkable for a calcium of 9.3, phosphorus of 3.7, and total protein of 6.8 with albumin of 2.9. Alkaline phosphatase was 110, GGT was 82, AST was 36, and ALT was 76. LDH was 315 and CK 55. His arterial blood gas on room air has a pH of 7.42, PC02 of 35, and PO2 of 75. His urinalysis had a specific gravity of 1.004 and a pH of 6. There were no red or white cells and the dipstick was negative. Sputum gram stain showed gram positive cocci in single chains. His chest x-ray had diffuse patchy infiltrate involving the right lower base with some volume loss on the right and a moderate right pleural effusion. He had a healed 6th rib fracture. The left side was unremarkable. His EKG showed some PVCs, and a normal sinus rhythm with a normal axis and nonspecific T wave changes.

The patient was admitted, and after blood and sputum cultures were obtained, the patient began on Unasyn 2gm IV q 6, thiamine, and multivitamins. PPD with Candida control was placed, and at 72 hours the PPD was negative with positive control. The patient subjectively improved, but still ran low grade fevers. Sputums were negative x 3 for AFB, and blood and urine cultures were negative. The pulmonary consultants suggested high resolution CT scan of the chest, pulmonary function tests, the addition of Clindamycin to his regimen, and fiberoptic bronchoscopy. His PFTs revealed a FEV1 of 1.60l (which is 57% of his predicted value), FVC of 2.16l (which is 63%), and FEV1 /FVC of 74% (which is 91%). Thoracentesis of his pleural effusion was unsuccessful. High resolution CT scan noted an abnormal increased density filling most of the proximal right main stem bronchus, with similar areas seen in the right lower lobe, of which the largest

was about 2cm. Atelectasis with almost complete consolidation was seen in the right lower lobe, with a small amount of patchy infiltrate and atelectasis in the right middle lobe. Some patchy changes were also seen in the left lingula. Adenopathy was noted in the mediastinum, around the great vessels, and in the pretracheal, carinal, and subcardinal areas. A small right pleural effusion was also noted.

The patient underwent fiberoptic bronchoscopy on hospital day 6. The upper airways, vocal cords, trachea, and left tracheobronchial tree were normal. The carina appeared swollen and slightly deformed to the right. Within the right main stem bronchus, there was a large calcific, polycystic, cauliflower like mass noted which bled easily on slight touch. Biopsies and washings were done. On hospital day 7, unofficial preliminary report of a bronchoscopy sample was given as squamous cell carcinoma, and radiation therapy was begun. The final pathology report revealed atypical squamous metaplasia, suspicious of but not diagnostic of malignancy, and radiotherapy was discontinued after he received a total of four treatments. Repeat sputum samples and further samples from the bronchoscopy also showed atypia. He had a "metastatic" workup which included a CT of the head which was normal, a bone scan which was normal, and a CT of the abdomen that showed no evidence of malignancy but multiple splenic granulomas were noted.

A diagnostic procedure was performed.

Dr. Surrett: This is the initial chest x-ray when he presented to the Emergency Room on the 9th of May. The obvious finding here is the parenchymal increased density at the right base. There may also be a little blunting at the right costophrenic angle. The left lung appears clear and the heart size is normal. There is some infiltrate in the right lower lobe. Also in the right middle lobe there appears to be increased density and volume loss. When he returned to the Emergency Room on the 11th of June, there is a marked increase in the abnormal density in the right lung. There is blunting, also. There is a subtle amount of shift of the bronchus to the right, which suggests volume loss. On the lateral we can see infiltrate throughout the lower lobe. On the 15th of June, the CT of the chest shows volume loss. In the mediastinum we can see some adenopathy. There is a node that is a little over 1cm and there is low density inside it, suggesting necrosis. This is right brachiocephalic vein and it is densely contrasted. There is calcium deposited at the carina. Just below the carina we can see this large abnormal density that is filling the right main stem bronchus. There is a small pleural effusion on the right, as well. There are very few things that are this high density on CT; most commonly this would be calcium. Metal is a little bit brighter and has a little bit of streak in it. Lung windows showed some mild emphysematous changes and we saw the calcifications in the spleen that suggested prior granulomatous infection.

Dr. Hudson: The biopsy that was obtained at bronchoscopy contains several fragments of bronchial mucosa with pronounced chronic inflammation and squamous metaplasia of the bronchial epithelium. It had some atypical features, but no tumor was seen in this specimen. Another view of this fragment shows the squamous metaplasia of the epithelium and underlying chronic inflammatory infiltrate. Over the course of several weeks, six specimens were sent for cytology. There were four sputum specimens and two bronchial washings. The only specimen that had significant findings was the post-bronchoscopy sputum, which contained some scattered atypical squamous cells and a heavy purulent exudate in the background. The cytologic features in this specimen do not meet the criteria for a diagnosis of malignancy; however, in this clinical setting (a patient with weight loss, a long term smoker, and a presumed endobronchial lesion), these changes were suspicious for a diagnosis of malignancy.

Dr. Nolan: I just want to begin my discussion with reviewing what I feel are the most important aspects of the case. This is a 50 year old with a history of ethanol and tobacco abuse who presents with a chronic febrile illness with constitutional symptoms and pulmonary infiltrates that questionably respond to antibacterial agents. His in-hospital evaluation included a workup for tuberculosis with a negative skin test and negative AFB smears x 3, followed by a CT chest that revealed a calcific density filling the right main stem bronchus with right lower lobe consolidation, mediastinal adenopathy, and a small pleural effusion. He is taken to bronchoscopy where a large calcific polycystic cauliflower like mass, which bled easily on slight touch, was found. I get the idea that it was presumed that he had post-obstructive atelectasis and pneumonia because he was very expediently taken to radiation therapy, I gather in an attempt to reduce the size of the tumor and relieve the obstruction. This was stopped when the pathology report came back. Part of the metastatic work up showed multiple splenic granulomas.

The easiest way to begin this differential was for me to steal this slide from Dr. Fishman's textbook of pulmonary medicine, which goes through the incidence of various disease processes that cause solitary pulmonary nodules. This really is not fair to call this man a

solitary pulmonary nodule since to begin with he had more than one calcific density in his lung, but also because in the strictest sense a solitary pulmonary nodule should be defined as a nodule surrounded completely by lung, smaller than 4cm with no associated atelectasis or hilar adenopathy. Of course, this man had both atelectasis and hilar adenopathy. I am working on the premise that the root cause of his problem was this calcific density which caused obstruction of his bronchus and at some point in time he had the density by itself and did not have the infiltrate and the adenopathy along with it. I hope that's the case. About 1 in 500 individuals on routine chest x-ray will have a solitary pulmonary nodule and this series sites that 40% are due to malignancies, 60% are benign, and overall 50% are caused by infectious granulomas. If you dissect out lesions that routinely calcify, you are left with six diseases. There are other processes that infrequently will calcify, like hydatid cysts, that I am just going to exclude because of their rarity. Patterns of calcifications on x-rays can give clues to the diagnosis. The first thing to mention is something called a chondromatous hamartoma, which I have never seen but just read about. These are rare benign tumors that occur intrabronchially and they typically will show what is called a "spiculated" or "popcorn" form of calcification which is thought to be fairly well pathognomonic. I'm going to put this fairly low on a differential diagnosis in as much as it is relatively rare, and also the other forms of tumor for the same reason and also because if this were a malignancy, I probably would not be up here talking and somebody else would. A metastatic tumor of mesodermal origin such as osteogenic sarcoma will also calcify. Bronchogenic carcinomas will rarely calcify; anywhere from 1-15%. These are generally not truly calcifications as much as they are thought to represent a malignancy that is eroding into a calcified granuloma. They either form small specks of calcium or this eccentric form of calcium where it looks like the mass effect is pushing the granuloma over to the side. This occurs very rarely with bronchogenic carcinoma. Overall, calcification is thought to be the most consistent sign of a benign lesion. Of the granulomatous causes, it's fairly easy to exclude coccidioidomycosis, which does routinely cause calcified granulomas, simply because we have no evidence that this man has ever traveled to an area endemic for coccidioidomycosis such as the Southwestern United States. There are rare cases of coccidioidomycosis that are highly infectious that occur outside the endemic area. There was a case in Arkansas about a mechanic who was working underneath a truck that had traveled throughout the Southwestern United States. The mechanic inhaled spores clinging to dirt underneath the truck and became ill. It would be remotely possible, but having no more of a history than that, I would put that low on the differential.

Tuberculosis can calcify and certainly that is a possibility, even with a negative PPD and three negative AFB smears. It's always possible this could be a calcification due to tuberculosis. If he had successfully walled off a tuberculosis infection, you would not expect the bacteria to be recovered in an expectorated sputum. It's always possible his PPD could be negative. I'll put that number two on my differential.

I think the most likely diagnosis is that this man had a calcification due to a histoplasmoma which I would like to discuss in more detail. Histoplasma generally appear on a chest x-ray seen as concentric rings of calcification; relatively solid calcification like this gentleman had. They can undergo central caseous necrosis and have rims of calcium. In autopsy studies of individuals who are living in areas endemic for histoplasmosis, 90-95% of adults at autopsy will have pulmonary calcifications. In one study, they could attribute histoplasmosis causing these calcifications in 60-70%, and in the same study the as authors felt that a lymph node calcification > 10mm had an 80% probability of being secondary to histoplasmosis. They also found accompanying splenic calcifications, as this gentleman has in 2/3 of the cases. He fits nicely in that aspect, having grown up in an endemic area, having the splenic calcifications, and having a large pulmonary calcification. Histoplasmosis would be number one in my differential.

To talk a little bit about histoplasmosis and its complications, I've always felt the histories of infections were interesting. I will just briefly mention the history of histoplasmosis. It was first identified in 1905 in the Panama Canal Zone, and this was at the time that the etiologic agents of malaria were being discovered. There was a young pathologist by the name of Darling, who had just finished residency and headed down to Panama. He was doing an autopsy and was looking for malaria. He found what he thought to be a malaria parasite, a Plasmodium, within a histiocyte in what was probably the first described case of fatal disseminated histoplasmosis. So, he called it Histoplasma. There is a staining artifact that occurs where histoplasmosis shrinks when it's stained so it is made to look like it had a capsule. Darling called it Histoplasma capsulatum. Out of three assumptions that he made, it was a Plasmodium within a histiocyte which was encapsulated, he got one right. But, he first described it

and it was named Histoplasma capsulatum. The reason for mentioning the history of it was that it wasn't until 1945 that anyone really recognized the scope of disease due to histoplasmosis. It was presumed, up until that time that pulmonary calcifications seen on chest x-ray were actually due to tuberculosis. In 1945, a Histoplasmosis skin test reagent had just been developed. Christi and Petersen began skin testing individuals who had pulmonary calcifications but negative PPDs. They discovered that the vast majority of calcifications on x-rays were probably due to Histoplasmosis, in as much as these individuals with negative skin tests for TB had positive skin tests for histoplasmosis.

A major endemic region is in the Central United States. This slide shows a classic study that will probably never be repeated. Two hundred seventy five thousand healthy Navy recruits who had lived their lives in a single county were skin tested on entry into the Navy and this really gave us the knowledge of the endemic region for histoplasmosis, mainly along the Mississippi and Ohio River Valleys. Skin testing in histoplasmosis is different from tuberculosis. In theory, if you convert a PPD to positive, it remains positive for the rest of your life. With histoplasmosis, your skin test becomes positive after an acute exposure and will wane over several years to skin test negativity. This, at best, is an underestimation of where histoplasmosis is because if you are not exposed to it for several years, your skin test reverts back to negative. We reside in an area that is heavily endemic for histoplasmosis. Histoplasmosis is a soil inhabitant strikingly more prevalent in old collections of avian and bat excrement. That is why Infectious Disease doctors like to ask people, "Have you ever taken a bull dozer and run over a chicken coup?", or "Do you go into caves?"; things like that, which always seem like inane questions, because these are the risk factors to exposure to histoplasmosis. The more of these little point sources you have of infected bird droppings, the more heavily endemic the area is. It is thought that mechanical disturbances of such sites greatly increase the number of aerosolized spores and greatly increases your risk of acquiring Histoplasma.

The spectrum of illness is really quite broad. I just wanted to dispense with two things I am really not going to talk about, i.e. the opportunistic infections. The first is disseminated histoplasmosis. This is thought to be due to a poorly described immune defect where, in individuals infected with histoplasmosis, their histiocytes are unable to kill the yeast. They have continued multiplication of the yeast forms within the reticuloendothelial system. It's not common, but we see it with a fair degree of regularity. We always worry about it. In past years, we have made a diagnosis at autopsy in elderly Veterans with a febrile wasting illness, so it is always thrown into a differential diagnosis of a fever of unknown origin. Some children will have hepatosplenomegaly, but in elderly, this presents as a chronic febrile wasting illness. The second is chronic pulmonary histoplasmosis and this is basically a structural defect of the lung. You have to have prior cavitary lung disease to get chronic pulmonary histoplasmosis. It superinfects old emphysematous blebs or cavitary disease due to TB.

With normal hosts, the usual infection is asymptomatic and there are literally millions of infections with histoplasmosis that occur annually. The vast majority of them are asymptomatic and about the only way you can tell is that people who have previously had negative skin tests for Histoplasma turn to positive skin tests for Histoplasma. Occasionally, you will see a rare symptomatic acute infection and even less frequently, you can see some of the rare complications of symptomatic acute infection. Acute pulmonary histoplasmosis is something that if you grew up in Mississippi or have spent more than 1 or 2 years here, you have already had. It has a 50-80% prevalence rate. The organisms have never been shown to elaborate any type of toxins so in and of themselves are non-toxigenic, but they are highly antigenic and most of the disease that is produced is produced by the host immune response. The two most important factors are the size of the inhaled inocula and the prior immune status of the individual. It is thought that no matter how many times you have been previously exposed, if you get a high enough inoculum, it can produce symptomatic disease. The typical disease is like an upper respiratory tract infection, a flu like illness, or a cold. Usually, it resolves spontaneously and the diagnosis is very rarely made. Typically, there are no radiographic findings. If you see these people acutely and get a chest x-ray, which is not very often done, 25% will have one or two small infiltrates on chest x-ray, or enlarged hilar nodes, or both. Visible calcifications on chest x-ray occur in about 1/4 of skin test converters. Otherwise, there is a paucity of physical findings.

There are some rare and rather strange complications from acute symptomatic histoplasmosis, one of which I think our patient probably had. I will discuss them briefly. During acute illness you see enlargement of lymph nodes since disease is mediated through cell-mediated immunity. One of the ways you make a diagnosis is from enlargement of mediastinal and hilar

lymph nodes. Sometimes you can have an extremely exuberant lymph node enlargement, particularly in children. It can cause some mechanical problems. It can cause partial tracheal obstruction, bronchial obstruction, esophageal obstruction, and rarely pulmonary artery or pulmonary vein partial obstruction. These are usually self limited. They resolve when the acute inflammatory process resolves and they usually don't require any therapy. In the literature, these complications have been treated with Amphotericin B and the authors thought that perhaps this spurred resolution of symptoms, but no one knows for sure whether treatment of these entities alters their course.

Acute fibrinous pericarditis is thought to happen when an inflamed caseous lymph node either is abutting the pericardium and causing infiltration or actually erodes through the pericardium and dumps caseous material into the pericardial sac causing inflammation. It is an acute pericarditis that presents like any other acute pericarditis. It has the same attendant complications of tamponade or occasionally pericardial constriction. It is self limited if tamponade does not occur. The diagnosis is frequently made on pericardiocentesis. Occasionally, you can find the causative organism. Pleural effusions are rare and caused by the same thing where you see a lymph node that is abutting the pleural space causing inflammation and an effusion. A couple of the other stranger things that occur include mediastinal granuloma with superior vena cava syndrome. You can see large masses of caseous mediastinal lymph nodes that mat together. They will break down into a single encapsulated lesion and get a very vigorous fibrinous response around this lesion. They are normally asymptomatic. On occasion, they will cause a superior vena cava syndrome and have to be surgically removed. A related entity is called mediastinal collagenosis. No one is really sure if this is a separate entity from mediastinal granuloma or just the worst, extreme form of a mediastinal granuloma, but it's an idiosyncratic host response where there is a constant laying down of fibrous tissue around the infected lymph node. It is not responsive to steroid therapy. It is not response to antifungal therapy. The fibrosis is slowly progressive. It can cause tracheal obstruction, bronchial or esophageal obstruction, or obstruction of major vessels. Patients are not very amenable to surgical correction and have a slow downhill course.

We have talked about how the granulomas can calcify and show up as a calcific density on chest x-ray. It is thought that the pulmonary infiltrate from acute disease undergoes a central cavitation and fibrosis, and with fibrosis it rounds up to form a nodule. The majority of these will calcify over a number of years. If they don't calcify, they continue laying down fibrous material around them very slowly and enlarge. It is not infrequent that someone is taken to surgery for removal of a solitary pulmonary nodule that turns out to be a histoplasmoma. On rare occasions, and this was described as far back as Hippocrates, these things will erode into a bronchus. It can discharge some caseous material after it erodes into the bronchus and you have a litholysis or the "coughing up of rocks". Most of the time patients will complain of coughing up sand or gravel. Occasionally, they will cough up a rock. I was a resident doing Pulmonary at the VA and we had a patient come in and say, "Look, I coughed up a rock!". My initial response as an intern was that you couldn't cough up a rock. The pulmonary fellow did inform me that he had. On very rare occasions, these calcified lymph nodes, instead of being coughed up, will simply erode into the bronchus and cause obstruction and I think that is what happened in this gentleman's case. He had a granuloma due to histoplasmosis that eroded into his bronchus and caused a bronchial obstruction. For that reason, I will give him a diagnosis of broncholithiasis due to Histoplasma capsulatum with a post obstructive atelectasis and pneumonia. Since it appeared to be a rather large lesion on bronchoscopy, I think the next diagnostic procedure was probably a thoracotomy to remove the obstruction.

Differential diagnosis: Broncholithiasis due to Histoplasmosis

Dr. Hudson: The right middle and lower lobes of the lung were resected and sent to surgical pathology for examination. There were several prominent calcified peribronchial lymph nodes. The largest measured 3cm in greatest dimension and contained central, white caseation necrosis. The adjacent proximal bronchi are compressed with narrowed, slit like lumens. These bronchi have been opened longitudinally and show very impressive post-obstructive cylindrical bronchiectasis, which extends almost out to the pleura. There are also patchy areas of consolidation throughout the lung parenchyma of both lobes. This section of the fibrocaseous lymph nodes shows central calcification and compression of the adjacent bronchus. This is another fibrocaseous granuloma and shows central caseation with compression of adjacent lung parenchyma and bronchus. There is marked peribronchial chronic inflammation. This is a section of bronchial wall which shows some of the changes which weaken the wall and lead to bronchiectasis. There is an intense

inflammatory infiltrate and destruction of smooth muscle and cartilage. This section of bronchial epithelium shows columnar epithelium, which has undergone metaplastic change to squamous epithelium. Note that these superficial cells slough off fairly easily. These are reactive squamous cells and may be picked up in cytology specimens (bronchial washings or sputum) as we looked at earlier. Also, the squamous metaplastic change impairs mucociliary function and drainage of the airways which sets the stage for infection. This section of some of the more distal airways shows marked acute and chronic inflammation within and surrounding the bronchioles. This section correlates with the areas of patchy consolidation that we looked at on the gross photograph, and it shows a pattern of organizing pneumonia. Note the dense fibrous connective tissue plugs which are occluding the alveoli and distal small airways. In addition to the large fibrocaseous granulomas, there are also old, hyalinized, inactive granulomatous nodules within the parenchyma of the lung. This is a healed lesion and shows no evidence of active granulomatous inflammation. Special stains for acid fast bacilli and fungus were done on the fibrocaseous sections. The acid fast stains are negative but the silver stains for fungus show the presence of some yeast forms. These are characteristic of Histoplasma. To summarize the pathological findings, this is a case of post-obstructive bronchiectasis and organizing pneumonia secondary to large calcified lymph nodes due to a previous Histoplasma infection.

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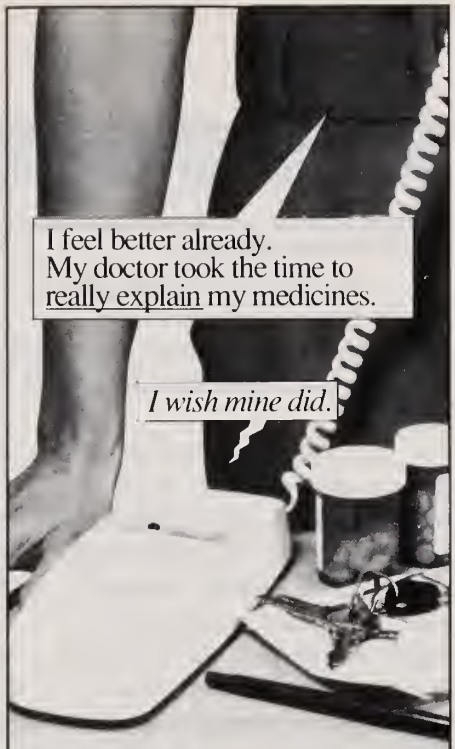
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***Dr. Files** is Professor of Medicine and Associate Chairman for Clinical Affairs, Department of Medicine.**Dr. Nolan** is Assistant Professor of Medicine;**Dr. Surrett** is a resident in the Department of Radiology; **Dr. Hamrick-Turner** is an Assistant Professor of Radiology;**Dr. Hudson** is a resident in the Department of Pathology; and **Dr. Allen** is an Assistant Professor of Pathology. **Drs. Guynes, Huey, and McMullan** were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1994-1995.*



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Mississippi Foundation For Medical Care

CCP Presentations

Cooperative Cardiovascular Project data presentations have been scheduled for January and February at several hospitals in the state.

In addition to this statewide project, other projects underway include transfusion, prophylactic administration of antibiotics, heart failure, blood pressure management, statewide immunization, stroke management, ACE inhibitors in diabetic nephropathy, ACE inhibitors in treatment of heart failure, and blood pressure management.

Many hospitals are responding energetically and enthusiastically to the studies; we hope every hospital will commit to this program during 1996.

This new year also brings the Fifth Scope of Work three-year contract for the Foundation with the Health Care Financing Administration to begin April 1, 1996. The emphasis continues on the Health Care Quality Improvement Program.

Forecasts and Projections

From a Heritage Foundation report, as highlighted in the November issue of Healthcare Trends Report: Assuming there is no change in the current Medicaid program, a forecasting model developed by the Heritage Foundation and Wharton Econometric Forecasting Associates projects that states will have to spend $688 billion of their money for health expenditures between 1995 and 2002. Total Medicaid spending over the period is projected to be $1.73 trillion. States would have to devote about 8 percent of their nonfederal revenues to the program. Pennsylvania was specifically mentioned as one of the hardest-hit states; it will have to devote 19 percent of its revenues to Medicaid, which would represent a $427 increase in the average taxpayer's bill. For 1990 to 2002, states' Medicaid contribution will increase 225 percent. According to the model in 1995, state-level spending for Medicaid grew 11 percent; total state spending is estimated to be growing at 8 percent annually. Nineteen states will have more than a 50 percent increase in their Medicaid payments over the 1996-2002 period, with Texas requiring the highest increase over seven years, almost 90 percent.

Medical School Enrollment—Up

The November Healthcare Trends Report, "The Monthly Digest of Business and Public Policy News," reports from a story in The New York Times that students are entering medical schools in brisk numbers. Rising complaints from physicians about the state of medical practice in the country have not decreased the numbers of applications to medical schools, with 1995 numbers to break the 1994 record. Applicants last year, some 45,365, doubled the number eight years ago. This year's numbers are already higher, according to the newspaper's statistics. The enthusiasm for medicine supports the notion that the transition to managed care for American medicine will be smoother than some experts have predicted. Interviews with medical students indicate that most are going into medicine because of altruistic motives rather than an escape from a bleak job market. Reforms have improved the lives of the students: rote memorization is being de-emphasized; long hours for residents have been decreased; and more part-time options are available. The median age for first-year students is up to almost 25, from 22 a decade ago. Forty-two percent of first-year students are women.

HMO Enrollment

Statistics show that as of Jan. 1, 1995, nationwide HMO enrollment topped 50 billion, a 17.3 percent increase from 1994. Pure HMO enrollment in commercial, Federal Employees Health Benefit Plan, Medicare, Medicaid and other segments increase 9.2 percent since Jan. 1, 1994. Medicare enrollment increased 15.6 percent; six states had the highest concentration of enrollment, nearly three-quarters of the total figure: California, Florida, Arizona, New York, Minnesota and Oregon. Open-ended HMO products were the fastest-growing segment of the industry in 1994, gaining more than 1.2 million members, according to The Interstudy Competitive Edge Industry Report, which showed HMOs as enrolling 19.4 percent of the country's population as of Jan. 1, 1995.

Facts and Notes

Among other notable facts from Healthcare Trends Report, which is edited and published in Bethesda, MD, by Sylvia Fubini, Ph.D.:

** Health benefit premium increases were held to 2.1 percent between 1994 and 1995, the lowest rate of increase since 1986. HMO premiums rose only 0.4 percent, the lowest growth rate of all plan types.

** Median net physician income in office-based private practice was up 5.7 percent for 1994.

—James S. McIlwain, MD,
Medical Director

Physicians' Recognition Award

Five MSMA members were named recipients of the AMA Physicians Recognition Award in December 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Philip Edwin Cranston, MD
Carlton Ralph Daniel, MD

North Central Mississippi Medical Society
L.C. Henson, MD

South Mississippi Medical Society
James Walter Holmes, MD

West Mississippi Medical Society
Walter E. Johnston, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Special Article

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
ANNUAL REPORT
JULY 1, 1994 THROUGH JUNE 30, 1995

Editor's Note: This is the first of a two-part article publishing the Medical Licensure Board's Annual Report. The INVESTIGATIVE segment will follow in the March JOURNAL MSMA.

The Mississippi State Board of Medical Licensure is the State's legally constituted licensure Board for physicians (M.D.s/D.O.s) and podiatrists (D.P.M.s). The Board is responsible for setting policies and professional standards regarding the practice of medicine and podiatric medicine; considering applications for licensure; conducting examinations for licensure; investigating legitimate drug traffic among medical practitioners under the State's Uniform Controlled Substances Act; conducting hearings on disciplinary matters involving violations of the State's Medical Practice Act; and keeping up-to-date records on all licensed physicians, osteopathic physicians and podiatrists in the State.

The Board is composed of nine physicians (8 M.D.s and 1 D.O.) appointed by the Governor, and meets bimonthly on the third Thursday beginning in January of each year.

The administrative functions of the Board are performed under the direction of its Executive Officer, P. Doyle Bradshaw. Twelve full-time staff members consist of: one division director; one branch director; four investigators; one licensing officer, professional; one accountant; one systems analyst; one secretary administrative, confidential; one secretary, principal; and one clerk senior. The office of the Board is located at 2688-D Insurance Center Drive, Jackson, Mississippi 39216.

LICENSURE DIVISION

Any physician, osteopathic physician, or podiatrist desiring to practice medicine in Mississippi must first obtain a license to do so by contacting the Board. When an inquiry concerning licensure is received, a questionnaire to elicit certain pertinent information is sent to the practitioner. Based upon the information given by the practitioner, a determination is made as to his/her eligibility for licensure. Queries are made to the American Medical, Osteopathic, or Podiatric Medical Associations; other states in which the practitioner is or has been licensed; National Practitioners Data Bank; Federation of State Medical Boards; and hospitals where the practitioner holds or has held staff privileges. If the information received is favorable, an application is sent to the physician.

During the year 1995, five hundred nineteen (519) NEW licenses were issued; seventy-five (75) TEMPORARY licenses were issued and eleven (11) LIMITED INSTITUTIONAL licenses were issued.

During the year 1995, the board experienced an INCREASE in three major functional areas of the Licensure Program as shown below:

Applications for licensure	56%
Written verification of licensure	18%
Renewal applications mailed	7%

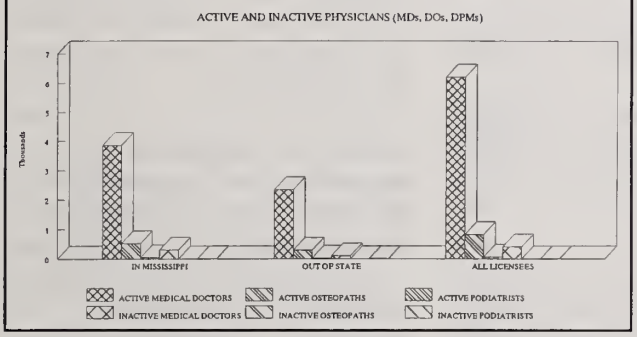
During the fiscal year ending June 30, 1995, the board processed six thousand, eight hundred seventy (6,870) annual renewals of Mississippi licenses.

Various graphs, which indicate statistical information regarding physicians licensed by this agency, follow. (See Graphs 3A through 3F.)

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
ACTIVE AND INACTIVE PHYSICIANS
FY95 JUNE 30

Printed: 08/01/95

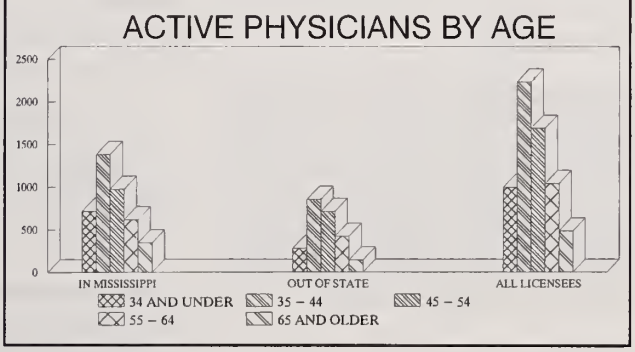
	IN MISSISSIPPI	OUT OF STATE	ALL LICENSEES
ACTIVE MEDICAL DOCTORS	3865	2343	6208
ACTIVE OSETOPATHS	130	47	177
ACTIVE PODIATRISTS	43	25	68
TOTAL ACTIVE	4038	2415	6453
INACTIVE MEDICAL DOCTORS	301	107	408
INACTIVE OSTEOPATHS	2	0	2
INACTIVE PODIATRISTS	3	4	7
TOTAL INACTIVE	306	111	417
TOTAL ALL PHYSICIANS	4344	2526	6870



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
ACTIVE PHYSICIANS BY AGE
FY95 JUNE 30

Printed: 08/01/95

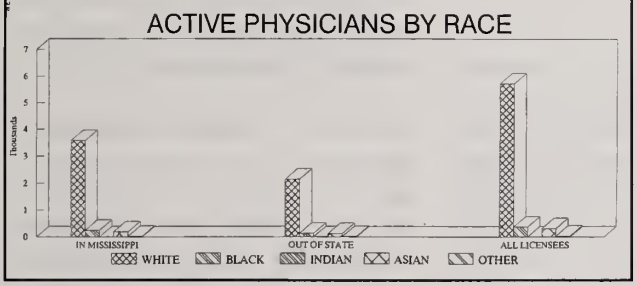
	IN MISSISSIPPI	OUT OF STATE	ALL LICENSEES
34 ANO UNOER	718	279	997
35 – 44	1381	856	2237
45 – 54	975	715	1690
55 – 54	620	423	1043
65 AND OLDER	344	142	486



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
ACTIVE PHYSICIANS BY RACE
FY95 JUNE 30

Printed: 08/01/95

	IN MISSISSIPPI	OUT OF STATE	ALL LICENSEES
WHITE	3579	2151	5730
BLACK	243	130	373
INDIAN	3	3	6
ASIAN	191	121	312
OTHER	22	10	32



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
NEW LICENSURE ISSUED
FY95 JUNE 30

Printed: 08/01/95

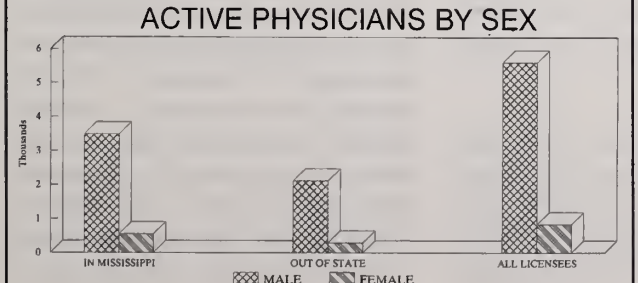
	1990	1991	1992	1993	1994	1995
NEW LICENSURE ISSUED:	348	341	369	360	482	519



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
ACTIVE PHYSICIANS BY SEX
FY95 JUNE 30

Printed: 08/01/95

	IN MISSISSIPPI	OUT OF STATE	ALL LICENSEES
MALE	3493	2123	5616
FEMALE	545	292	837



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
LIMITED INSTITUTIONAL LICENSURE
FY95 JUNE 30

Printed: 08/01/95

	1990	1991	1992	1993	1994	1995
LIMITED INSTITUTIONAL LICENSURE	1	7	11	14	7	11



ACHARYA, AJAY A., Gulfport. Born India, August 12, 1952; MBBS, SCB Medical College, Cuttack, India, July 1976; internal medicine residency, Millard Fillmore Hospital, Buffalo, NY, June 1989 - June 1992; elected by Coast Counties Medical Society.

ALEXANDER, MYRNA ELLEN. Born Laurel, MS, July 25, 1957; MD Meharry Medical College, Nashville, TN, 1982; internal medicine & cardiology residency, Henry Ford Hospital, Detroit, MI, 1983-1992; elected by Central Medical Society.

ANDREWS, SUSAN D., Jackson. Born Detroit, MI, May 6, 1955; MD Michigan State University, East Lansing, MI, 1982; one year internship, William Beaumont Hospital, Royal Oak, MI; family medicine residency Univ. No. Carolina Hospital, Chapel Hill, NC 1984-86 and Duke University Medical Center, Durham, NC, 1986-87; elected by Central Medical Society.

BOWERS, LISA A., Oxford. Born February 15, 1963; MD Medical University of South Carolina College of Medicine, Charleston, SC, 1991; interned and anesthesiology residency, same 1991-95;
elected by North MS Medical Society.

DONALD, ROBERT L., III, Pascagoula. Born July 29, 1963 in Fort Worth, TX; MD University of Mississippi School of Medicine, Jackson, MS, 1989; family medicine residency, same, 1993-95; elected by Singing River Medical Society.

ELLISON, RICHARD B., JR., Jackson. Born Alexandria, LA, April 2, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1988; diagnostic radiology residency, Baylor College of Medicine, Houston, MS, 1989-93; magnetic resonance imaging fellowship, same, 1993-94; elected by Central Medical Society.

HARDING, ERIC D., New Albany. Born Pontiac, IL, Sept. 10, 1965; MD Vanderbilt University School of Medicine, Nashville, TN 1991; internal medicine & pediatrics residency, Nashville, TN Hospitals, 1991-95; elected by North MS Medical Society.

IVEY, TIMOTHY R., Quitman. Born May 10, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family medicine residency, 1992-95; elected by East MS Medical Society.

IYER, RATHI, V., Jackson. Born India February 24, 1943; MBBS Gandhi Medical College of Osmania, Univ. Hyberabad, India 1966; interned one year, Worcester City Hospital, Worcester, MA; pediatric residency, Detroit General Hospital/Sinai Hospital, Detroit, MI; hematology/oncology fellowship, Children's Hospital of Michigan, Detroit, MI; elected by Central Medical Society.

LANDRY, LARRY J., McComb. Born Lake Charles, LA, May 17, 1951; MD University of Texas Medical Branch, Galveston, TX; interned one year, same; urology residency, University of Missouri Medical Center, Columbia, MO, 1979-82; elected by South Central Medical Society.

LETARD, THOMAS P., Biloxi. MD Louisiana State University Medical Center, Shreveport, School of Medicine, Shreveport, LA., 1985; elected by Coast Counties Medical Society.

McARTHUR, WILLIE L., Fayette. Born Brookhaven, MS, October 13, 1943; MD University of Mississippi School of Medicine, Jackson, MS, 1977; family medicine residency, same, 1977-80; elected by Homochitto Valley Medical Society.

McGAUGH, RONALD C., JR., Meridian. Born September 17, 1963; MD University of Arkansas School of Medicine, Little Rock, AR 1992; one year internship; elected by East MS Medical Society.

MARTIN, ANDREW A., Greenville. Born Toccoa, GA, August 18, 1958; MD Emory University School of Medicine, Atlanta, GA, 1984; pathology residency, Tulane University/Charity Hospital, New Orleans, LA, 1989-94; surgical pathology fellowship, Baylor College of Medicine/Texas Medical Center, Houston, TX 1994-95; elected by Delta Medical Society.

MOORE, DAVID SCOTT, Hattiesburg. Born Hattiesburg, MS, June 17, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; anesthesiology residency, University of Texas Medical Branch, Galveston, TX, 1991-95; elected by South MS Medical Society.

NALLUIR, KRISHNA R., Gulfport. Born India, May 1, 1949; MBBS, Guntur Medical College, India, 1974; interned Frankford Hospital, Philadelphia, PA 1983-84; neurology residency BMHC, Montefiore Medical Center, Haccom, Bronx, NY 1984-87; fellowship in neuro muscular diseases, State University of New York, Brooklyn, NY, 1987-88; fellowship in sleep medicine, Mobile Infir-

mary, Mobile, AL, 1991-93; elected by Coast Counties Medical Society.

SCALES, MARY P., Greenwood. Born November 14, 1931; MD Tulane University School of Medicine, New Orleans, LA, 1958; ob-gyn residency, Charity Hospital New Orleans, LA, 1958-62; elected by Delta Medical Society.

SEYMOUR, MORRIS, B., Hattiesburg. Born Elberton, GA, July 6, 1959; MD University of Alabama School of Medicine, Birmingham, AL 1986; general surgery residency, same, 1986-89; orthopaedic residency, same 1989-94; fellowship in spine surgery, Baylor College of Medicine, Houston, TX, 1994-95; elected by South MS Medical Society.

SMITH, BARBARA E., Southaven. Born Collins, MS, December 10, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1989; family medicine residency, University of Tennessee Medical Center & St. Francis Hospital, Memphis, TN, 1989-92; elected by Desoto County Medical Society.

SULLIVAN, DAVIS LEE, Hattiesburg. Born Mobile, AL, November 18, 1957; MD University of South Alabama School of Medicine, Mobile, AL, 1991; ob-gyn residency, University Medical Center, Jackson, MS, 1991-95; elected by South MS Medical Society.

WATAK, A. K., West Point. MD Medical Academy in Lodz, Poland, 1981; hospital residency in Astrzebie Zdroj City Hospital, Poland; internal medicine residency, Silesian General Hospital, Cieszyn, Poland, 1983-86; internal medicine intern one year, Abington Memorial Hospital, Abilgton, PA 1990-91; internal medicine residency, same, 1991-93; elected by Prairie Medical Society.

WATTS, RISHER, JR., Sumrall. MD Howard University College of Medicine, Washington, DC, 1962; elected by South MS Medical Society.

WEE, ABELARDO S., Meridian. MD Faculty of Medicine & Surgery University of Santo Tomas, Manila, 1976; elected by East MS Medical Society.

WILKINS, ROBERT G., Hattiesburg. Born New York, NY, March 20, 1960; MD Louisiana State University School of Medicine, Shreveport, LA, 1986; internal medicine residency, LSU Medical Center, Shreveport, LA, 1986-89; cardiology fellowship, Tulane University Medical Center, New Orleans, LA, 1991-94; interventional cardiology fellowship, Tulane University Medical Center, New Orleans, LA, 1994-95; elected by South MS Medical Society.

REINSTATEMENTS:
David L. Dugger, MD, Gautier
Robert C. Forbes, Jackson
Binford T. Nash, Jr., Jackson
Laramie C. Triplett, Jackson
Wm. P. Warfield, III, Pascagoula
Charles M. Webber, Jackson
H. Lee Wineland, Gulfport

DEATHS:
EZELL, CLOYD L, Jackson. Born Newton Co, May 12, 1915; MD University of Illinois College of Medicine, Chicago, IL, 1950; interned one year, U. S. Marine Hospital, New Orleans, LA, 1950-51; pathology residency, Mississippi Baptist Hospital, Jackson, MS, 1958-59; died January 20, 1996, age 80.

NEWTON, I JAMES, Greenville. Born Arkansas, October 18, 1914; MD Vanderbilt University School of Medicine, Nashville, TN, 1939; interned one year, University of Iowa Hospitals, Iowa City, Iowa; ob-gyn residency, Vanderbilt University Hospital, Nashville, TN 7/40 - 4/41; died July 17, 1995, age 81.

MASSENGILL, FRANK C., Brookhaven. Born Brookhaven November 27, 1910; MD University of Tennessee School of Medicine, Memphis, TN, 1940; interned one year, Methodist Hopsital, Memphis, TN; general practice residency, U.S. Army, 1941-45; died December 18, 1995, age 85.

MSMA
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PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office.

WATS 1-800-962-2230
Jackson, 853-5453
Bill Kindred (Ext.5453)

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Journal MSMA Display Classified ads 1x insertion cost $100.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge.

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Dr. Kenneth A. Haller, Pediatrician, East St. Louis, Illinois, Member, American Medical Association

In one of the nation's poorest communities, Dr. Kenneth Haller is working not only to save children's lives, but to bring dignity to the lives of their parents.

He is the type of physician who brings distinction to our profession. He is the type of physician who upholds the highest ideals of medicine. He is also a member of the American Medical Association (AMA).

"I read the Principles of Medical Ethics of the AMA and was impressed by it. I'm proud to be a member," says Dr. Haller.

You are invited to join Dr. Haller and to join with him in his efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

American Medical Association

Physicians dedicated to the health of America


As appeared in Time, Newsweek and US News and World Report.
The Clinton Administration has just unveiled its plan for health system reform and parts of it have us concerned. We're concerned that this plan will keep your doctor from giving you the personalized care you deserve. We're concerned that limits to what your doctor can do for you will be controlled by bureaucrats.
We do think this plan is a good place to start. It includes a lot of things we've been pushing for from the beginning. Like health insurance for everyone and a requirement that employers must help pay for it. But it still has a long way to go.
That's why the 300,000 member physicians of the American Medical Association (AMA) are insisting that any final reform legislation put the health of our patients first. This plan not only involves billions of dollars.
It involves millions of lives.
And all of us must remember which is most important.
This is the moment of truth.
This is indeed the moment of truth for America's health care system. And now is the time to voice your concerns... before this plan becomes law. Find out where your doctor stands and let him or her know what you think. And for more information on health system reform, write the AMA, Department 4900, 515 North State St., Chicago, IL 60610.
American Medical Association
Physicians dedicated to the health of America
AMERICAN MEDICAL ASSOCIATION

Breast-Conservation Treatment



AT LEAST ONE-THIRD OF ALL BREAST CANCER PATIENTS COULD HAVE LUMPECTOMY FOLLOWED BY RADIATION THERAPY

The American Cancer Society, the American College of Surgeons and the American College of Radiology have agreed that women whose early breast cancer was detected by mammography are candidates for breast-saving treatment. This treatment consists of lumpectomy with axillary node sampling followed by radiation therapy to the breast. According to new standards, women with small lumps, those with tumors as large as two inches, and even some women with positive nodes may be candidates for this treatment.

The purpose of the breast-conserving treatment is to treat these patients adequately but with a good cosmetic result. Stage for stage, patients treated in this manner have the same longevity and the same freedom from local recurrence as those treated with mastectomy.

For copies of the standards please contact Keri Sperry, American College of Radiology, 1891 Preston White Drive, Reston, VA 22091.

acr

AMERICAN COLLEGE OF SURGEONS

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Nomination
1995 Community Service Award

The **Annual Physician Award for Community Service,** sponsored by Mississippi State Medical Association is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. All nominations should be submitted to the Mississippi State Medical Association by February 26, 1996.

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A $500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

Nominations should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 26, 1995. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.

"Certificate of Merit" Award Nomination

Local Medical Society Public Relations Program

In 1992 the Council on Public Information, in recognition of the many community programs sponsored by local medical societies, added a new category to the Media Awards Program. This category is for **local medical society public relations programs.**

A narrative and supporting documentation of a project conducted in 1995 should be submitted to the Council on Public Information any time prior to **February 26, 1996.** A "Certificate of Merit" will be awarded during the MSMA annual session to the medical society or societies with the program that best furthers the positive image of physicians.

Projects should be community oriented, for example, many societies have set up pre-participation physical examinations for athletes, others have offered medical screening programs for the homeless and health fairs for schools and communities. These are all excellent examples of programs that should be submitted.

The Council on Public Information encourages you to seek the assistance of your local MSMA Alliance in preparing the written materials and supporting documents.

Supporting documents may include all or some of the following: a narrative of the event, numbers of people involved, newspaper clippings, newsletter or magazine articles, advertisements, and photographs. Those persons coordinating the event should be identified.

Entries should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, by February 26, l996. For further information contact, Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.

PHYSICIAN FOLLOW THROUGH



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Trustmark....475

US Air Force....476

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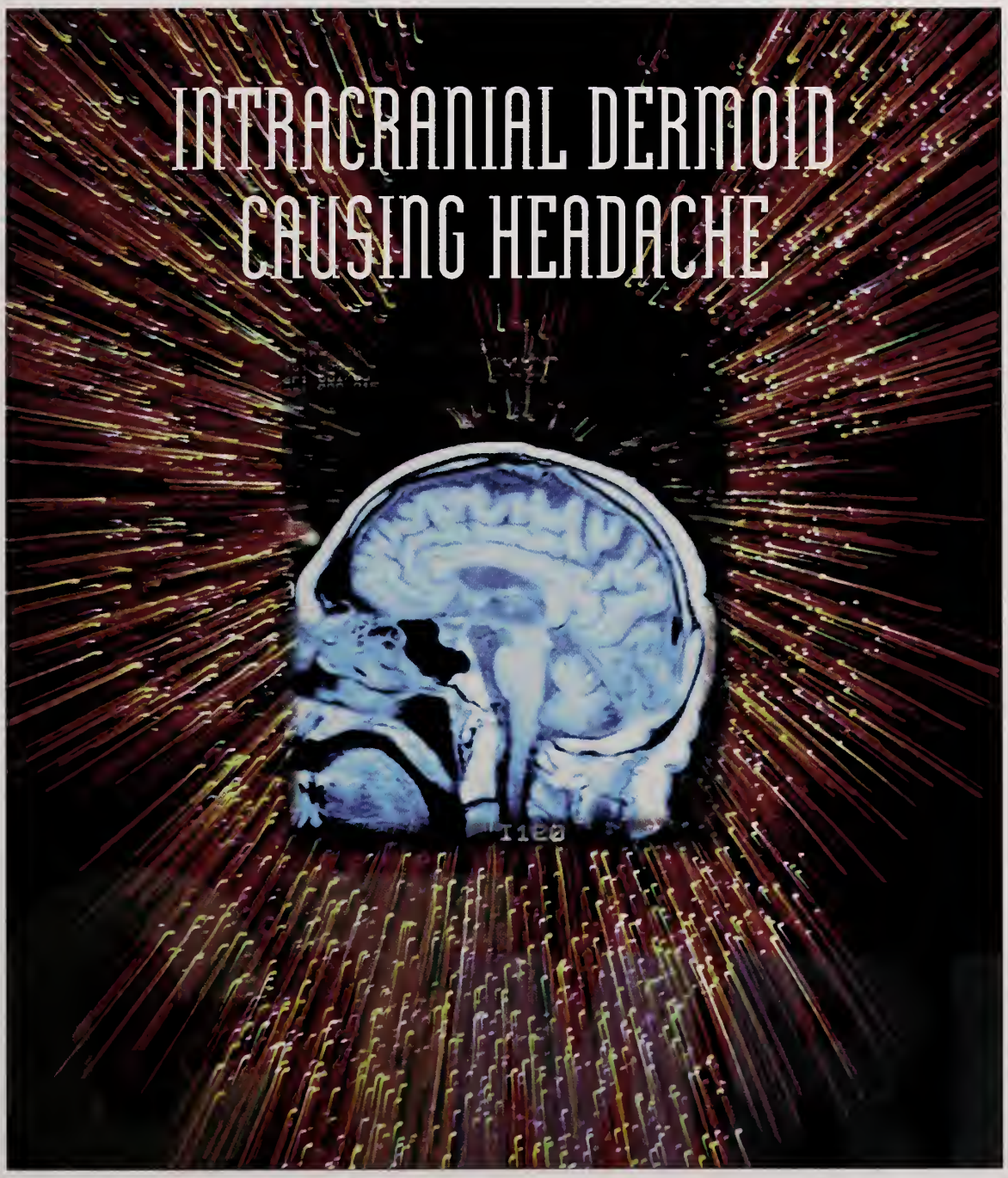
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OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

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128th Annual Session Scientific Exhibits

The MSMA 128th Annual Session will be held May 1-5, 1996 in Biloxi, Mississippi at the Grand Casino Resort Hotel. Physicians who would like to reserve **Scientific Exhibit Space** should write: **Scientific Exhibits, MSMA, PO Box 5229, Jackson, MS 39296-5229** or Fax the following information to (601)352-4834.

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128th Annual Session 140th Anniversary Meeting: May 2-5, 1996

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Opening of Exhibits House of Delegates & Reference Committee Meetings for all members.
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Specialty Societies Meetings
Golf Tournament
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SA 4

Seminars on Current Health Issues/Legislation
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MSMA President's Reception / Membership Party

SU 5

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Letters

How About Listening To The Choir

The American public, employers, and the Government of the United States are trying to get a message to the medical profession. We as physicians can no longer afford to preach to the choir or anyone else. It is time that we begin to listen. In medical school, we were all taught to be good listeners. Why can't we heed the cries of our society, amend our ways, and strive to meet their medical needs. The populace perspective is that we deserve the titles that are being laminated upon us such as Dr. Greedy or Dr. Cruel. There are many people who believe that our delivery of healthcare is not only inhumane. It is uncivilized .

These are the messages that the choir is singing to us. Admittedly, we are divided amongst ourselves in the medical profession. Many of our medical societies are at each others throat struggling for control. Many providers of healthcare currently advertise, market, and openly extol their superiority for purposes of obtaining market share. It is doubtful that as a profession we will ever agree on how medical care should be managed, delivered, billed, or provided. What we should be able to agree on are some very fundamental principles. Are we not as professional persons committed to put the health of our society and the well-being of our patients above ourselves We must decide and proclaim whether or not healthcare is an inalienable right of all American citizens or is it to be available only to the privileged. Certainly we should be able to address this issue with a some degree of unanimity. Can we not agree the universal coverage of all American citizens should be An ideal to strive for? Would it not be a goal for all patient to have a freedom of choice when it comes to selecting their physician? Can we not agree that a fee for service system of reimbursement would be preferred to capitation or decapitation' Should not the cost of medical care be spread equally and fairly across the entire population of the United States? Do we need to have medical expenses as the number one cause of personal bankruptcy in America? Can we as physicians morally accept the fact that 50 million Americans will have no health insurance at all? Should these not be the goals of our profession If we cannot agree on these ideals, then we have neither heard the choir nor honored our oath as a physician. We must identify, codify, and respond to these needs as a professional organization and as individual members of organized medicine. If we fail to heed the choir, we shall surely have our creditability continue to erode. These ideals, as lofty as they may appear, are achievable. It will require a tremendous effort on the part of organized medicine and a very strong working partnership with the Federal Government to bring this about.

Basically the solution to many of our problems lay in a healthcare delivery system similar to Medicare. Extending Medicare to the entire population of the United States of America through a federal system of taxation with regional administration functioning as a single payer is the only way to provide medical care to the people. There is a model for this healthcare system just north of our border in Canada. Unfortunately, this has been so maliciously maligned by organized medicine in the United State of America that we are forbidden to consider it. Consider it merits. It is cost effective, it is fair, it is equitable, it is honorable, and it is preferred by the overwhelming majority of the choir and even most preachers.

John D. Bower, M.D.
President of the Mississippi Chapter,
Physicians for a National Health Program

Dear Editor,

From the depths of my embarrassment, I would like to offer further comments, if I may, on Dr. South's article, which I have already shared with her.

I speak, not only as a person without the obligations entailed in supporting a family, but as someone who belongs to a professional organization and who wonders why membership in a second, duplicate group is mandatory.

It seems to me it is like saying, "If you are a Republican, you must also belong to the Democratic party to belong to the state society."

There are, I believe, well over 100 Osteopathic physicians in our state, who provide essential and excellent care for our patients, many of whom would otherwise have no medical attention. Many of us belong to the American Osteopathic Association instead of the AMA. I have a hard time understanding why I have to join the AMA in order to belong to the state society, since I am already a member of the AOA. Yes, 1 have paid my annual dues, which are close to $500, and I am less than enthusiastic about paying another high fee, particularly when we have such a high number of indigent patients in our practice.

I am not an allopath: I am an osteopath. Since the state has recognized my training and has licensed me to practice medicine in Mississippi, it seems to me I should be able to participate in the state society as an osteopath who is duly credentialed by my professional society and whose meetings I attend. And whose dues I pay.) Is it possible that our state could follow the example of many other states and require membership in the organization of the physician's profession?

Peace and health,
Sister Anne Brooks, D.O.

The Honorable Ken Stribling **January 30, 1996**
Chairman, Subcommittee Two
House Public Health and Welfare Committee
Post Office Box 1018
Jackson, MS 39215

Dear Mr. Chairman,

On behalf of the membership of the Mississippi State Medical Association, I want to express our support of House Bill 1142 which would license physician assistants. In this bill, the State Board of Medical Licensure would set the rules and define the scope of practice for PA.

MSMA believes that physicians should have the flexibility to employ physician assistants who work directly under the supervision of their employing physician. PA are trained at medical schools along side medical students and are taught to assist a physician in his/her direct care of patients.

Despite what you may have been told, licensure of PA would not adversely affect the livelihood of any other health care group. There are less than 40 PA currently in Mississippi. Most of these PA are employed at federal agencies such as the VA and have successfully worked along side nurses and nurse practitioners in federal facilities since nurse practitioners were licensed in the 70's. Because of the tremendous underserved population in Mississippi, the addition of PA to the health care community would only serve to increase access and make physician's care more attainable to those who need it most.

We encourage you and your subcommittee to favorably report HB 1142 to the Public Health Committee and champion additional support for its passage.

Sincerely,
D. Stanley Hartness, Jr., MD
MSMA President

cc: The Honorable Bobby Moody

Myron W. Lockey, M.D. **February 14, 1996**
Editor, Journal of the Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39202

Dear Dr. Lockey:

The members of the Mississippi Academy of Physician Assistants and the American Academy of Physician Assistants sincerely appreciate the endorsement of proposed PA legislation by the Mississippi Medical Association. Unfortunately the bill has been held hostage in the Public Health and Welfare subcommittee. This legislative tactic prevents open debate and vote by the full committee. Since the majority of Mississippi counties are designated health professional shortage areas for primary care, Physician Assistants would welcome debate on how PA legislation would impact health care in Mississippi. The facts provide overwhelming evidence that PA enabling legislation will offer Mississippi physicians a time tested method of extending quality health care services to more citizens.

Recent articles in the Journal of the Mississippi State Medical Association and the Journal of the American Medical Association completely deflated the opposition's long promulgated erroneous assertions regarding PA. The Mississippi medical community now clearly understands that PA are **dependent** practitioners who are qualified by graduation from an accredited PA program and/or certification by the National Commission on Certification of Physician Assistants. Simply stated, PA are highly educated and nationally certified health care providers who can not practice unless employed by a physician. Dependent practice is, and has always been, a basic tenet of the PA profession.

Once again, thanks for your support. PA are committed to helping physicians provide quality health care in Mississippi.

Respectfully,
George L. White Jr., PA-C, MSPH, Ph.D.
Acting Chair, Department of Physician Assistant Studies, Professor and Assistant to the Dean for Clinical Research
College of Allied Health Professions, College of Medicine, University of South Alabama

Case Report: CT and MRI of Intracranial Dermoid Causing Headache

James R. Zimmerman, M.D.
Frank A. Raila, M.D.
William A. Russell, M.D.
Robert R. Smith, M.D.

Key Words: Headache, Intracranial Dermoid Cyst, Computerized Tomography, Magnetic Resonance Imaging

Abstract

This case shows an unusual intracranial cause of chronic headache in a 30- year-old female. Computerized tomography and magnetic resonance imaging were used to demonstrate an intracranial, dermoid cyst located in the left middle cranial fossa. Droplets of fat-like material, which leaked from this cyst, were present in the basilar subarachnoid spaces and left sylvian fissure. Since the surgical excision of the cyst, the patient has not had any severe headaches.

INTRODUCTION

Intracranial dermoid cysts are rare, benign, congenital tumors comprising .6% or less of all intracranial tumors[1]. The extrusion of dermoid cyst material is unusual and can be associated with serious clinical events such as aseptic meningeal irritation resulting in cerebral ischemia[2,3,4]. We describe the use of computerized tomography (CT) and magnetic resonance imaging (MRI) to demonstrate this tumor with evidence of leakage that was thought to be the cause of this patient's chronic headaches.

CASE REPORT

The patient was a 30- year-old woman who had headache complaints for the past fifteen years. These were categorized as a combination of migraine-like headaches with aura, visual changes, and tension-like headaches involving the occiput and posterior cervical region. There was no history of trauma or sinus disease. The surgical history was noncontributory. A physical

and neurological examination was unremarkable. The patient was placed on non steroidal anti-inflammatory medication. She continued to have severe headaches and computerized tomography of the head was obtained.

Cranial CT revealed a 2.5 cm intracranial, extra-axial mass located in the medial aspect of the left middle cranial fossa **(Figure I A,B)**. Some calcifications were noted in the capsule of this lesion. The mass had homogenous low density. The Hounsfield units (HU) measured in the center of this mass resulted in a value of -40 that placed it in the category of fatty material [5]. Magnetic resonance imaging was obtained to get multiplanar views of this lesion before surgery. The cystic lesion was clearly identified and the signal characteristics within it were similar to fat **(Figure 2A,B)**. Low signal areas in the capsule of this lesion were considered due to calcification. The perspicuity of MRI was better than CT for displaying the droplets of fat-like material located in the subarachnoid space and left sylvian fissure. After intravenous gadolinium contrast administration, there was no evidence of any significant enhancement, which was expected.

An angiogram was performed to find out if this fatty material involved the vascular structures on that side. This study was normal which is a typical finding for this lesion.

At surgery, fatty droplets were observed in the subarachnoid space and sylvian fissure. The dermoid cyst was removed; a small calcified portion of the cyst that was adherent to vascular structures and cerebral cortex was left in place. The patient's postoperative course was uneventful. No neurological deficits were present. She was discharged on the third postoperative day. On follow-up visits she has not had any of the previous severe headaches to date. Pathological examination of the lesion proved calcification in the fibrous wall of the cyst which contained pearly-like keratin and hair. These findings are consistent with a dermoid cyst.

DISCUSSION

Headache is a complaint in more than half of the patients who visit physicians. It can result from intracranial, systemic disease or psychological reaction to the environment. Headache requires careful study to rule out underlying disease that deserves treatment. Brain tumors can produce symptoms fulfilling the International Headache Society Criteria for migraine [6]. Headaches due to intracranial disease are diagnosed primarily by physical examination and laboratory findings. When necessary, the use of CT and MRI are powerful tools for diagnosing the cause of headaches [7]. The clinical approach to the diagnosis and variety of headaches is beyond the scope of this case report.

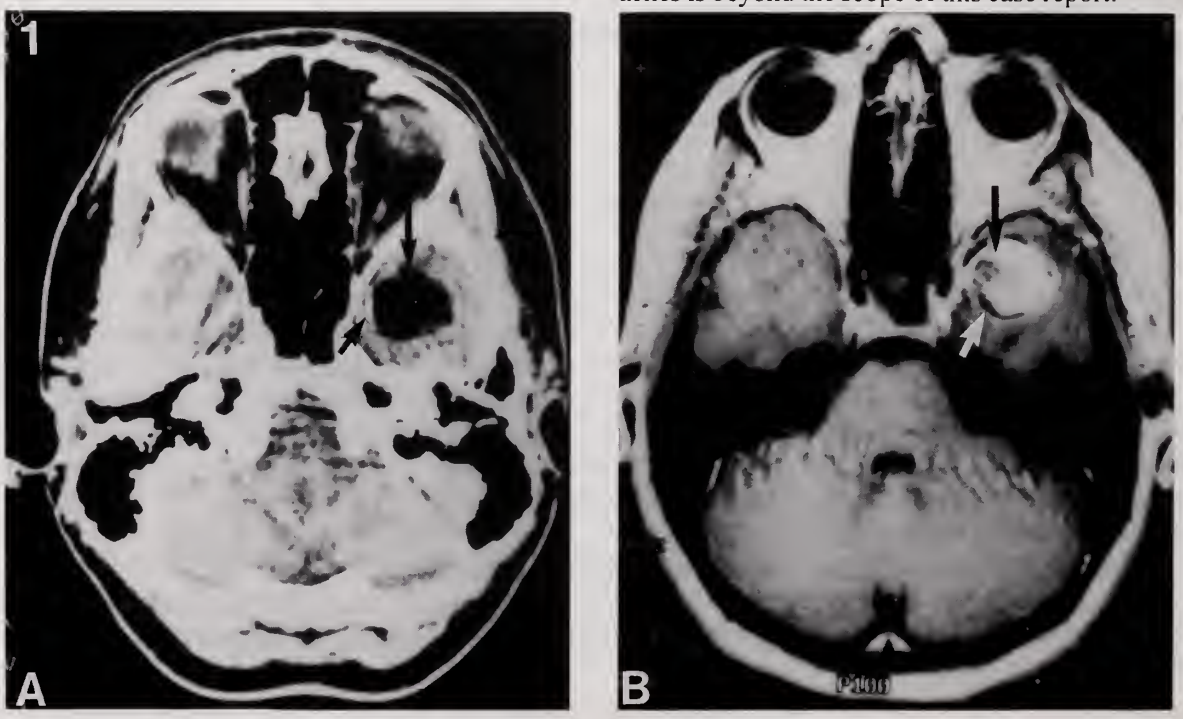


Fig.1 A; Axial CT shows a 2.5 cm diameter dermoid in the left middle cranial fossa (long arrow). The density within the dermoid is non-specific but can be characterized by measuring the Hounsfield Units within it. Note the high density calcification in the capsule (short arrow).B; T1 weighted (TR; 750 msec., TE; 16 msec) axial MRI showing the same lesion (lomg, black arrow). Note the high signal within the dermoid compared to its density on CT. Low signal due to calcification is seen in the capsule (short, white arrow).

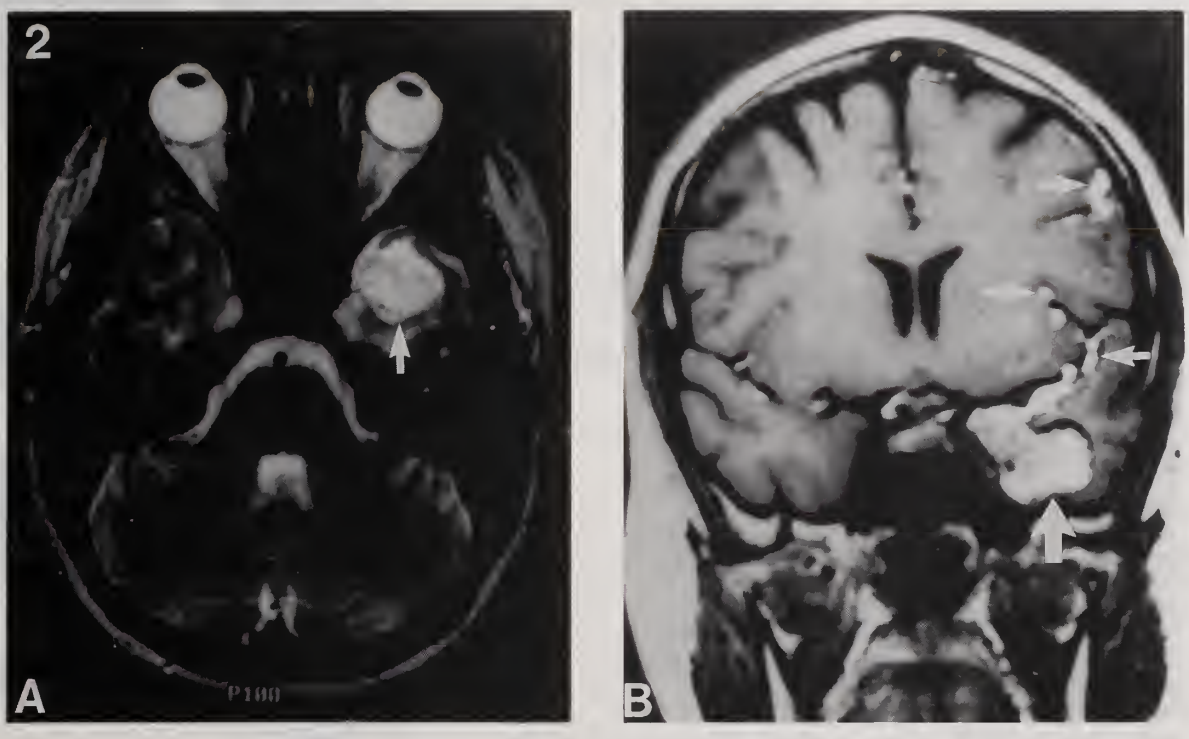


Fig.2 A, T2 weighted (TR; 3000 msec. TE; 102/ef msec) axial MRI demonstrating the dermoid cyst containing like compounds, keratin and hair (arrow). B; TI weighted coronal MRI revealing a dermoid cyst (large arrow) in the left middle cranial fossa next to the cavernous sinus. Note the droplets of extruded fatty material from the dermoid cyst in the subarachnoid space and the left Sylvian fissure (small arrows).

The clinical presentation of intracranial dermoids is variable. They can cause headache, seizure, dementia, hemiparesis or coma[2]. Rupture can be associated with aseptic chemical meningitis with vasospasm causing infarction and death[1,5]. It is rare for a dermoid cyst to rupture. If it is located in the cerebral ventricular system, hydrocephalus can occur due to granuloma formation in the aqueduct of sylvius. Cortical sulcal widening may be due to the effects of the meningitis[2,8]. Fat embolism after rupture of a dermoid cyst into the cavernous sinus has been described[9]. Other reports say that sometimes cyst leakage can be relatively benign, therefore, the patient may be asymptomatic[10].

The etiology of dermoid cysts is due to the inclusion of epithelial elements at the time of embryonic neural groove closure, between the third and fifth week of gestation[11]. Dermoids can be uni- or multi-loculated and contain only ectodermal elements. They are composed of a dense fibrous capsule lined with stratified squamous epithelium and constitute of dermis such as sweat glands, sebaceous glands and hair. The glandular secretions, epithelial desquamation, keratin and lipid breakdown products such as cholesterol will enlarge the tumor. Dermoids are seen primarily in the first three decades of life and occur equally in males and females. Their frequent locations are the spinal canal, parasellar region, midline subfrontal area, quadrigeminal cistern, interhemispheric fissure, posterior fossa, and the intraventricular system[5,12]. A posterior fossa dermoid cyst can present in the ventricular system or intradurally, the latter is associated with the torcular herophili. Intraspinal dermoids are the result of embryonic epithelial inclusions or iatrogenic implants after spinal tap[12].

Plain skull x-rays may sometimes demonstrate a dermoid as a faint rounded lucency with flakes or streaks of rim calcification and possibly a fluid-fluid level[11]. However, this examination is only of historical interest as it does not approach the accuracy of CT or MRI.

The use of CT can accurately demonstrate these lesions and also measure the attenuation of the material they contain in Hounsfield units. Fatty material has an HU range between -20 and -150. MRI can also accurately detect a dermoid cyst by its signal characteristics and is able to display leakage of fatty material more clearly than CT. In addition, MRI has the advantage of multiplanar capabilities that would be important for surgery[1,11].

The treatment of a dermoid cyst is complete excision, however, this may not be possible in some cases, but fortunately recurrence is rare even after subtotal resection[1,11].

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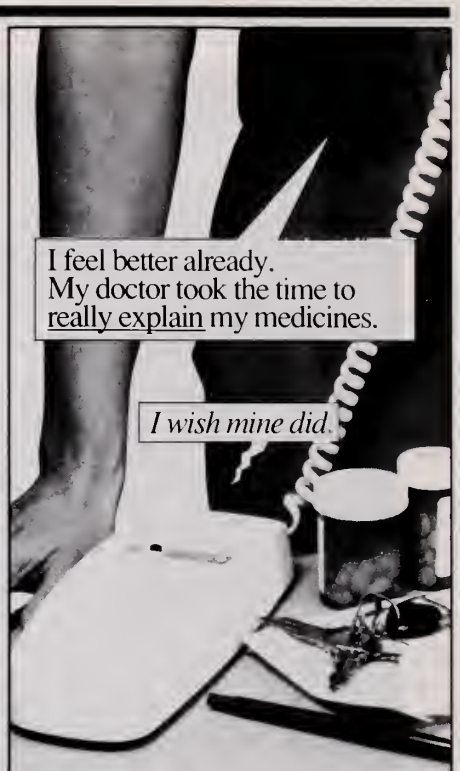
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Dr. William A. Russell *is Associate Professor of Neuroradiology and*

Dr. Robert R. Smith *is Professor Emeritus and Attending Physician at the University of Mississippi Medical Center Radiology Department.*



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Assessment of Premenstrual Glycemic Control in an Insulin Dependent Woman

Joel Herring, M.D.
Judy Gearhart, M.D.

Statement of Problem and Background: Prior research and patient reporting suggest a deterioration of carbohydrate metabolism during the luteal phase of the menstrual cycle as evidenced by several parameters including GTT, glycosuria, and insulin levels. (1) Little exists in the literature about prevention of increased glucose in the luteal phase. This clinical observation seeks to assess luteal phase hyperglycemia and possible intervention by identification of ovulation.

Design: Single Case/Control.
Methods:

An insulin dependent diabetic woman of reproductive age was asked to participate in the study. We sought out a patient who was premenopausal (between age 20 and 50), who was capable of monitoring glucose values, and who was available for participation in the study.

The patient was provided with a glucose monitor and test strips, a digital thermometer, and monthly calendar records for data collection. To encourage accurate records, a patient educator personally counseled the patient regarding use of the glucose monitor and thermometer and methods of recording data pertinent to the study. Test strips for the glucose monitor were provided as an incentive for active participation, and continued supplying of the strips was contingent upon accurate and complete records from the patient as evidenced by a monthly calendar record.

During the following year, the patient kept a daily record of the following:

a) basal body temperature--to allow researchers to verify ovulation.

b) fasting glucose-- to establish a pattern of normal glucose values and recognize possible luteal phase hyperglycemia.

c) insulin doses--to help researchers identify usual doses of insulin supplements given for higher glucose values.

d) menstrual period--to help ensure that the patient was ovulating and to help determine time of ovulation.

The intent of the study was to observe and identify trends in the patient's glucose values. If the luteal phase was associated with hyperglycemia, then the patient would be further educated regarding identification of ovulation (basal body temperature and/or cervical mucous changes) and better control of blood glucose levels by alterations in diet, exercise, or insulin regimen.

Results:

This study demonstrated higher average glucose values in the postovulatory (luteal) phase as compared to the preovulatory (proliferative) phase of the menstrual cycle in this patient. (See figures.)

The patient has been informed of the findings and is continuing to log daily parameters. She has been asked to record interventions such as diet, increased insulin dosage, exercise to improve glucose values in the luteal phase. Follow-up is planned in three months.

Significance:

This study has implications for diabetes management in menstruating women. Increased monitoring of ovulation in diabetic women may be an adjunct to therapy in that women may be able to make therapeutic adjustments to prevent hyperglycemia in the luteal phase.

References:

1. Diamond et al. Fertility and Sterility. Vol 50(3):1988.
2. Hammond et al. Patient Care. December 15, 1992.

Dr. Judy Gearhart *served as preceptor and is an Associate Professor practicing in the Department of Family Medicine at the University Medical Center in Jackson.*

Joel Herring *was a research assistant in 1993 and is now a medical doctor.*

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D. Stanley Hartness, Jr., MD

The President's Page

At Least Slow Down and Sniff the Roses

It was probably the closest thing to a cult experience that I'll ever know.

We faithful (though generally misunderstood) Michael Feldman fans recently flocked to Jackson for the live broadcast of his weekly NPR program, "Whad' Ya Know?" And from the tacky pink flamingos to the zany audience interviews, we weren't disappointed. Except maybe for that petrified blues singer...

When I tuned in the following Saturday to catch Feldman's impressions of our Magnolia State, one of his infamous quiz questions ("How many doctors wish they were not practicing medicine?") and the answer ("one out two") caught me off guard. But after reflecting on the turbulent climate of seductive managed care scenarios, frustrating third party interference, and suffocating government regulations, the reality of the response settled in.

Physicians come in many varieties, but there's one thing we have in common: We are all very, very busy. Medical school and residency did a good job of preparing us to encounter common and rare diseases and to perform specific techniques and procedures. But who taught us how to balance our busy lives to prevent professional burnout?

A timely article in Family Practice Management reminded me that peace and meaning in our lives rest on achieving inner balance, outer balance, and interpersonal balance.

Achieving inner balance is giving the inner self its due through opportunities such as silence by simply passing time in quiet; by solitude, often a prerequisite

to meaningful silence; and by slowing down. Between the demands of practice and family, many physicians ironically never experience such moments except when they themselves are ill.

Outer balance refers to activities that involve movement out into the world such as exercising, living simply, taking time to find a little corner of nature, and serving. Consider something unrelated to medicine such as helping construct a Habitat for Humanity house or serving as chaperone for your child's field trip.

Finally, there is balance between us and those who have linked their life journeys with ours--our families and closest friends. How do we nurture and develop these relationships?

I offer these suggestions: Through play, the purposeful pursuit of pleasure with others; through love, the soul nourishment for the beloved and the lover; through forgiveness, the measure of all thoughtful and caring human beings; and finally, through celebration by making a big deal out of special occasions, creating rituals, and grabbing every opportunity, however small, to gather with others and experience the gift that life is.

Stanley

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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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Editorial

JOURNAL OF THE
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THE ART AND SCIENCE OF MEDICINE ARE NOT INSEPARABLE

In a personal discussion with the chief executive officer of a large business regarding current health care polices and administration, and choosing physicians for his health care program, he stated, "I do not care about anything except that the person graduated from a medical school and is a licensed medical doctor. I do not care about other parameters normally associated with the practice of medicine; a doctor is a doctor.

In a recent news release the chief executive officer of a large Health Maintenance Organization referred to the practice of medicine as the application of scientific acts in the management of patients, and that the "art of medicine" had no place in the current health arena.

These two incidents reflect the current thinking by many of those involved in health care management. It was indeed interesting to point out to president of the company that his thoughts regarding the selection of physicians was in stark contrast to the normal operating policies of his company, which has a very large personnel department, and thoroughly screens all job applicants. His company does not practice the philosophy that an engineer is an engineer, or a lawyer is a lawyer, etc. Why then this contrast when selecting physician participants in their health care program? In reality I guess it is not too difficult to understand what is going on. In hiring 11 other professionals the company interest centers around the earning potential of the professional, and what they will make for the company, whereas, physicians represent a cost potential, and therefore the cheapest is the best.

At no time did either of the above demonstrate any concern for the quality of care rendered to the employees and other recipients. I cannot comment regarding the MO executive but the company president readily heads up to the mid-west for his medical care, and I am sure he thoroughly screens and chooses his physicians, and would bet that he does it on the health policy restricting others in the company from doing the same.

Why these changes in health care administration? What is the driving force behind this movement? Prior to the late 1960s the doctor-patient relationship had been a close and cherished bonding between the two. Since then numerous events have brought us to the current state. Some of the lesser reasons are: a highly mobile society, a more enlightened society, enhanced communications, a more expectant patient group, litigation, and technological innovations. While these have impacted significantly on the health care industry they are not the most significant reason for the current changes. The single most powerful driving force was the discovery by the business world that there was money in the management of health care. This alone has been the stimulus for most of the current changes. Historically physicians as a group have not been trained, or oriented, in large scale money management, and while continuing to practice using established methods of the past, have been out maneuvered by the experts in that field.

The proposal to obliterate the "art of medicine" from scientific medicine represents the latest movement in managed care. What a totally blind approach this represents. Our patient population has been a pretty savvy group and, when allowed to do so, choose physicians who are scientifically up to date and administer that knowledge in a caring manner. As physician we must continue practicing the "Art and Science" of medicine. To do otherwise would be abandoning our patient population, and that most certainly would hasten our great downfall. Maintaining the doctor patient bonding is our greatest asset in countering this recent trend. **-Myron Lockey, Editor**

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Use of Ace Inhibitors in the Treatment of Heart Failure

A MISSISSIPPI CLINICAL IMPROVEMENT PROJECT

Background:

June, 1994 - the Agency for Health Care Policy and Research published a clinical practice guideline recommending early assessment of left ventricular function (LVF) and the use of ACE inhibitors in eligible patients.

Heart failure is the number one DRG for hospitalized Medicare patients in Mississippi and is often costly.

Studies have shown that using ACE inhibitors in both symptomatic and asymptomatic heart failure patients with reduced LVF can reduce morbidity and mortality.

Purpose:

Establish baseline data on use of ACE inhibitors at discharge in treatment of heart failure.

Establish baseline data on documentation of objective evaluation of LVF in Medicare patients admitted for treatment of heart failure.

Improve use of ACE inhibitors and documentation of objective evaluation of LVF in treatment of heart failure.

Methodology:

Foundation abstraction tool collected information on documentation of assessment of LVF and ACE inhibitor use in Medicare admissions for heart failure.

Findings:

Project data collection revealed 42.6% of patients were not discharged on ACE inhibitors.

The percentage of patients discharged on ACE inhibitors was similar in both bedsize categories (< 100 beds and > 100 beds).

Of the patients discharged on ACE inhibitors, larger hospitals documented LVF evaluation 73.5% of the time vs. 28.4% in the smaller hospitals.

Documentation of the numerical value of the LV ejection fraction also occurred less in smaller hospitals compared to larger hospitals.

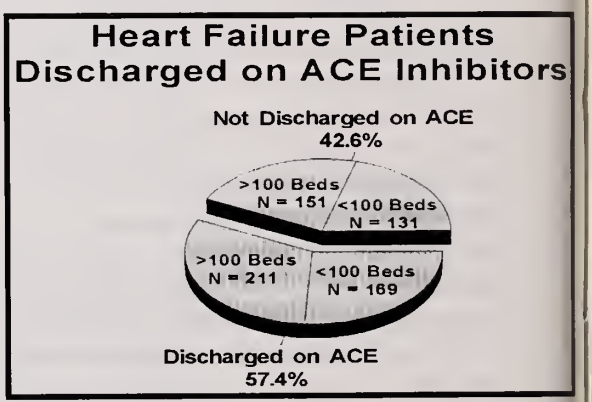
Of heart failure patients with a LV ejection fraction > 45% who were discharged on ACE inhibitors, 60% in smaller hospitals compared to 72.2% in larger hospitals had a diagnosis of hypertension.

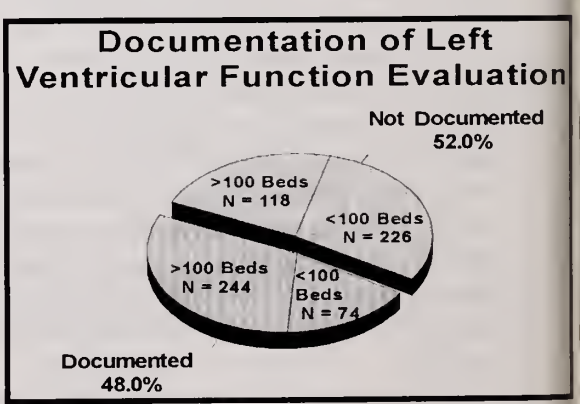
Conclusions:

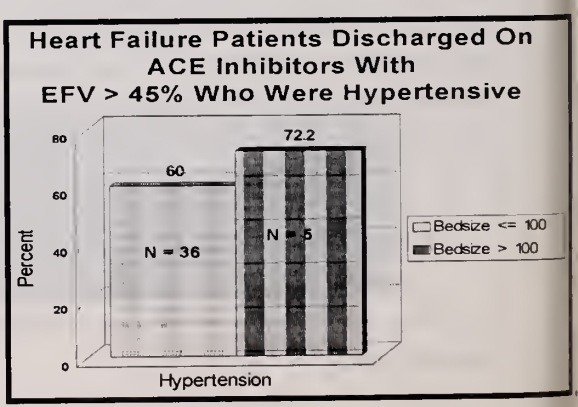
Opportunities for improvement were demonstrated.

Foundation shared findings with providers in April 1995.

Educational video is available through the Foundation.







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Buyers' Health Care Action Group Introduces Direct Contracting

The Buyers' Health Care Action Group, a powerful coalition of 24 employers including Dayton Hudson, General Mills, and 3M, will begin contracting directly with provider groups rather than with health plans starting in 1997. BHCAG will issue a request for proposals (RFP) by the end of 1995, and responses will be due by March 1996. The final selection will take place by the end of June 1996, and the new model of contracting will take effect in January 1997.

At a seminar sponsored by the Minnesota Medical Association, Hennepin Medical Society, and Ramsey Medical Society on November 8, Ann Robinow, BHCAG director of strategic planning, told an audience of providers, health care consultants, and clinic managers why BHCAG wants to introduce a new delivery model and what the employer group will be looking for in the new "care systems."

Why Stop Contracting With Plans?

Although BHCAG is sometimes credited with starting Minnesota's merger mania, BHCAG now believes market consolidation has gone too far, according to Robinow. With only three or four major players that have overlapping networks of providers, the distinctions among provider groups are blurred. There is no market advantage to the provider group in being efficient or providing exceptionally high quality. "Bigger multi specialty clinics are not necessarily more efficient; they sometimes cost more," Robinow said.

"Direct contracting offers a way for smaller multispecialty groups to access the system without being bought," Robinow said. Practices would have to work together and be integrated in some way, but they would not have to be under a plan umbrella. "We want to turn decisions back to the medical community," Robinow said. Currently, there is a lack of trust between employees and health plans, she said. Employers want to avoid having physicians tell patients that the blue pill is better, but their employer health plan will only pay for the pink pill. Direct contracting would put medical decisions back in the providers' hands, allow employees to choose their own physicians, and preserve the doctor patient relationship.

If BHCAG is not satisfied with competition under the new contracting arrangement, it will have no alternative but to consider supporting a health care system that would be heavily regulated by the state, Robinow predicted.

Highlights of BHCAG's 1997 Model

The new contracting arrangement will have these features:

•Employers will pay for their employees to receive the medical services in a standard benefits set offered by an array of "care systems." There will probably be two benefit level options.

•Employees will pay the cost difference among the various care systems .

•Care systems will compete for patients on the basis of cost, quality, and service.

•Provider payment will be based on a fee schedule adjusted to reflect the care system's success in meeting its claim target.

•Retrospective risk adjustment will prevent care systems from being penalized for having a sicker population of patients.

•BHCAG will designate some Centers of Excellence.

•BHCAG will provide most administrative services, such as claims processing, customer service, and education.

•Care systems will be expected to perform continuous quality improvement and utilization review.
The care system may contract for these services.

What Is a 'Care System'?

A "care system is provider group with a primary care focus that offers a full continuum of care. "There is no right way to form a care system," Robinow said. "BHCAG will con tract with whoever can provide the best quality and service. Price efficiency will be passed on to consumers, who will consider cost in their selection of care systems." Decisions about gatekeeping, which guidelines to follow, and other managed care techniques will be up to the care system. She suggested three possible models:

1) provider-hospital organizations;

2) large health care systems such as Park Nicollet or Mayo; or

3) physician organizations that contract for specialist and hospital care.

Specialists will contract with various care systems. Primary care providers will be able to participate in only one BHCAG care system.

How Big Should a Care System Be?

"There is room at the table for all kinds of arrangements," Robinow said, but added that BHCAG would prefer smaller groups that create intellectual ownership at the provider level. A care system shouldn't be too small. It would need at least 2,000 patients in order to generate statistically valid information, Robinow said. Accountability is important.

'Virtual Capitation' Maintains ERISA Protection

Maintaining their ERISA protection as self-insured employers is important to BHCAG members, who operate in different states and do not wish to be subject to varying state taxation and regulation of their employee benefits plans. Because capitation would put BHCAG outside ERISA's circle of protection, BHCAG has designed a hybrid it calls "virtual capitation." Employers pay each individual claim as they would in a fee-for-service arrangement, but the provider fee schedule is based on the care system's success in meeting its claim target, the care system's estimate of the cost of providing care per member per month.

Care Systems Will Set Claim Targets

In its RFP, BHCAG will define its standard benefits set and tell prospective care systems the historic range of costs of providing that set of benefits per member per month. Each care system will submit bids called "claim targets. " BHCAG expects eight to 10 bids in its first response. Employees will pay the price difference among the care systems' claim targets. For instance, if the employer contributes $100 per month and the employee chooses a provider whose claim target is $110, the employee pays $10 per month. This system will return competition to the patient/provider level. A care system might bid low to attract a greater market share if it believes it is efficient enough to provide care for that price. Care systems that bid high will have to provide quality and services that justify the higher cost to the employee, or they may not survive in a competitive market.

BHCAG will compare each care system's claims performance with its target bid and will move the providers' future reimbursement up or down accordingly. The goal is to bring actual experience in line with the claim target. For a standard patient population, if the care system's claims are lower than the claim target, the fee schedule conversion factor will be higher in the next quarter. If the claims are higher than the target, the fee schedule will be lower. There will be no retrospective recovery or payment of money. The care system will be paid for all the services provided. Since the claims target is based on a standard population of patients, retrospective risk adjustment will be used to make sure a care system is not penalized for serving a sicker population of patients. It is important that the risk adjustment be retrospective, Robinow said. "Hindsight is 20/20."

One participant suggested that BHCAG consider the number of employee sick days when they evaluate the care systems. The value of preventive care shows up in a more productive work force.

Where Do Health Plans Fit In?

"The role of health plans is evolving," Robinow said. BHCAG will buy administrative services from the health plans. In addition, care systems might contract with the plans for help in becoming more efficient. For instance, they might ask the plans how they can reduce their number of inpatient hospital days.

What Are the Legal Obstacles?

Robinow stressed that it is the care system's responsibility to avoid legal problems as they integrate small group practices into a care system. Discussions about prices raise potential antitrust problems. Robinow recommended that providers who are considering forming a care system talk to an attorney in order to avoid the risk of price-fixing charges. The MMA and AMA legal staff are currently involved in an analysis of these issues.

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Annual Election For Board of Directors Underway

The Foundation for Medical Care mail box is brimming these days as physicians participate in the annual board of directors election. Nominations for the official ballot in the election have been received from throughout the state.

Ten new board members will be elected to two-year terms and announced at the Annual Session May 2 in Biloxi. They will join ten members who were elected last year.

The first part of the election procedure includes seeking suggestions for the ballot. A nominating committee appointed by the board will prepare the ballot, which will be mailed to the physician membership in March.

All physicians are encouraged to participate in the election. "This ballot is sent to each physician with a return envelop enclosed. This envelop, returned with the secret ballot, stays sealed until the official board committee convenes to open and count the ballots," said J. S. McIlwain, M.D., medical director. "The board is very active in maintaining the presence of the Foundation in these pivotal years of health care changes. The nominating committee will make a concerned effort to ensure that most all regions of the state are represented in the election choices."

Physicians whose terms close this year include the board chairman for the past two years Dr. George Abraham, Dr. Jack Causey, Dr. Hugh Gamble, Dr. Barney Guyton, Dr. David Hall, Dr. Karl Hatten, Dr. Thomas Holden, Dr. John Paul Lee, Dr. Glenn Peters and Dr. Hardy Woodbridge.

Terms expiring in 1997 include those of Dr. Tim Alford, Dr. W. R. Arnett, Dr. Thomas Fenter, Dr. Joe Files, Dr. Carolyn Gerald, Dr. John Hassell, Dr. William Henderson, Dr. Francis Morrison, Dr. Samuel Peeples and Dr. Eugene Webb.

Physicians currently serving on the executive committee include Dr. Abraham, Dr. Peters, Dr. Fenter, Dr. Gerald, Dr. Morrison, who is treasurer of the board, and Dr. Peeples, vice-chairman.

Health Care Quality Improvement Program Efforts Continue

Medical Director Dr. Jim McIlwain and Dr. Alton Cobb, clinical coordinator, continue their visits to hospitals throughout the state in sharing Cooperative Cardiovascular Project (CCP) data. So far eight meetings have been held in the Foundation's participation in the national project.

Members of the Analysis and Education department recently presented highlights of the Foundation's HCQIP progress at the American Medical Peer Review Association (AMPRA) meeting in Anaheim, Calif. Statistician Tony Horn was featured in a session focusing on alternative and innovative reporting and presentation methods of CCP data which differ from HCFA's CCP data analysis tutorial. Horn's emphasis was on clarifying CCP algorithms and automating, customizing and programming CCP presentation packages with Microsoft Excel and Visual Basic for applications. The program updates the CCP report so that it automatically has the most up to date information for any hospital selected. Because the report is well laid out and easy to read and adapt, copies of the program have been requested by other PROs.

Dr. Candace Keller, clinical coordinator, and Horn presented a program on a continuous quality improvement tool and process for assessing a hospital's CQI strengths and weaknesses. The software program used to analyze the data and to determine the hospital's capacity, as well as how the knowledge is applied, was also shared.

Physicians' Recognition Award

Five MSMA members were named recipients of the AMA Physicians Recognition Award in January 1996, six in February. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

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Wilford Joel Patterson, MD

Coast Counties Medical Society
Chas Edward Slonaker, MD
B. Frank Vogel, MD

Northeast Mississippi Medical Society
Elbert Asa White, MD
James W. Ervin

Singing River Medical Society
John Joseph McCloskey, MD

South Mississippi Medical Society
Jack Colbert Evans, MD
Clyde Russel Allen, MD
Pacita C. Rubio, MD

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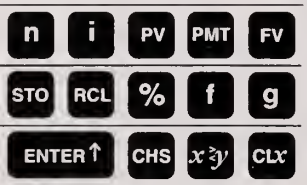
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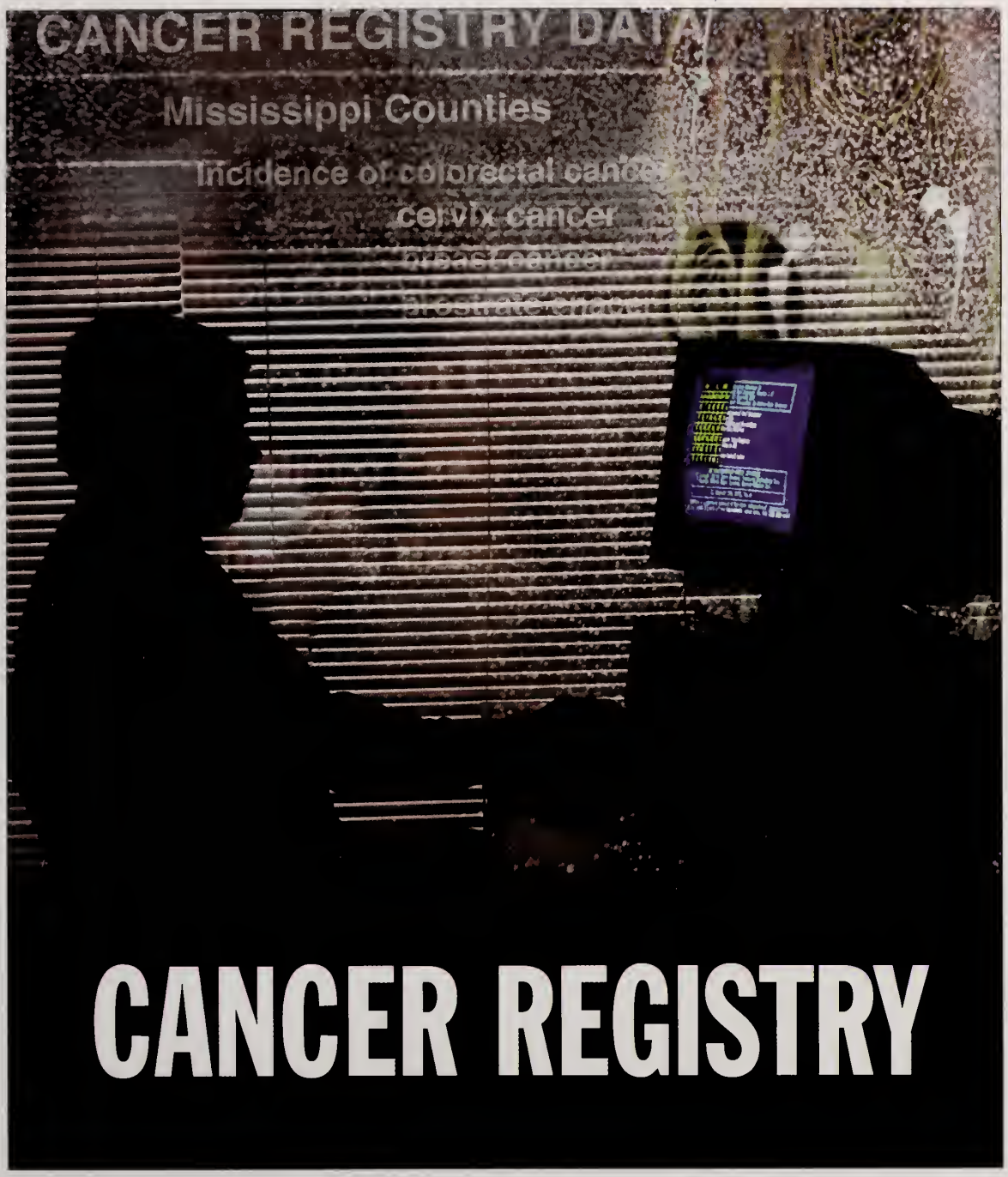
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CANCER REGISTRY

MISSISSIPPI STATE MEDICAL ASSOCIATION

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Volume XXXVII, Number 4

140th Anniversary Meeting Scheduled

Plan to attend MSMA's big 140th Anniversary Meeting at the Grand Resort Hotel and Casino, May 2-5, 1996 in Biloxi and participate in policy meetings, educational programs and social occasions with your colleagues from throughout the state. Speakers will address the hottest current health issues and legislation at seminars scheduled May 3-4. MSMA's House of Delegates and Reference Committees will meet May 2 to debate and decide the association's policies and positions. All members of the association are encouraged to participate in this process either as a delegate from their component society and/or as a member speaking before a Reference Committee of the House of Delegates. All actions taken by the House of Delegates result from recommendations from Reference Committees which conduct open hearings. Social occasions include the annual MSMA Membership/Alliance Party and AMA/ERF Auction, the MSMA President's Reception and medical alumni gatherings. Golf and fishing occasions are scheduled for your relaxation and if you still have time left the casino is open 24 hours daily. Call 1-800-354-2450 for reservations at the Grand and mention MSMA's meeting for a room discount.

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General Program

TH 2	Opening of Exhibits House of Delegates & Reference Committee Meetings for all members. MSMA/Alliance Auction & Party
FR 3	Seminars on Current Health Issues/Legislation Specialty Societies Meetings Golf Tournament Medical Alumni Socials
SA 4	Seminars on Current Health Issues/Legislation Specialty Societies Meetings Deep Sea Fishing Rodeo Tennis Tournament MSMA President's Reception / Membership Party
SU 5	Adjourned Meeting of House of Delegates

Case Report: Mississippi's New Central Cancer Registry Design and Implementation

Alan D. Penman, MBChB, MSc, FRCS
Bruce T. Brackin, MPH
Judy T. Moulder, RRA, CTR

Introduction

Last year state and federal funding was obtained to create a central cancer registry for Mississippi. The 1994 Mississippi Legislature funded the core of the program, and this funding was used to appoint a Cancer Registry Director. The Mississippi State Department of Health (MSDH) also obtained a five year grant from the Centers for Disease Control and Prevention (CDC) for cancer registry development. Utilizing these funding sources, the MSDH is embarking on a long awaited effort to establish a much needed central population-based cancer registry. This article describes the need for such a registry, the steps to be taken, and the accomplishments to date. Some potential uses of data from the registry are also discussed.

Need for a Central Cancer Registry

Statewide cancer prevention and control interventions, as well as academic research programs, require accurate cancer incidence / prevalence data. Mississippi has sixteen hospital tumor registries in the state, which are valuable sources of data for evaluating treatment and outcome, but because of case selection bias and lack of denominator data they cannot provide accurate data on cancer incidence / prevalence in the wider community. Only a true population-based registry with a high degree of completeness in reporting can accomplish this.

Twenty to thirty years ago, one could (for most cancers) estimate cancer incidence and prevalence fairly accurately from cancer mortality data, which are routinely collected by the MSDH Bureau of Public Health Statistics. However, thanks to advances in the detection and treatment of cancer, mortality is no longer a good indicator of incidence or prevalence. Currently, cancer incidence / prevalence data for the state can only be estimated from national data extrapolated to Mississippi (e.g. data from the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute).[1]

Steps in Implementation

A registry has been defined as "a file ..... containing uniform information about individual persons, collected in a ystematic and comprehensive way, in order to serve a predetermined purpose".[2] It is a longitudinal or prospective method of epidemiological investigation, based on a geographically-defined population, similar in some respects to a cohort study. However, with a register, new cases are continually being added as they are ascertained, and information on cases is continually being updated in a defined, systematic manner.[3] The main difficulties in running any disease registry are the need to be constantly searching for new cases, the need to handle data on a large number of people, and the need to ensure data quality, including avoidance of duplication.[4]

The aim of the MSDH registry will be to provide accurate, timely data on cancer incidence / prevalence by type of cancer, age, sex race, occupation, and place of residence (initially by county but eventually by census tract). Careful planning is needed to ensure that the quality of data to be collected meets the necessary standards, and numerous tasks need to be accomplished before the first data can be collected. A decision will need to be made about which data elements will be collected, based upon guidelines from the American Association of Central Cancer Registries (AACCR), now the North American Association of Central Cancer Registries (NAACCR).[5] Reporting mechanisms will be determined by consultation with each reporting source. The key sources for identifying cancer cases will be hospital tumor registries and pathology offices / laboratories. Careful consideration will be given to deciding who is to be responsible for abstracting / editing data and the method of transmitting data to the MSDH, particularly at smaller institutions such as hospitals without tumor registries, physicians' and pathologists' offices, and laboratories. The aim will be to create an electronic (paperless) system that will place little if any additional burden on the reporting sources.

In addition, reciprocal reporting arrangements with other states will have to be made, since approximately 10% of Mississippi residents who die from cancer, die out of state (Bruce T. Brackin, personal communication). CDC will provide valuable technical assistance to help guide establishment of the registry. Training for key personnel will be available on site and at the CDC.

Accomplishments to Date

A Cancer Registry Director has been appointed (JAM), and support staff are now being sought. An Advisory Group has been established, consisting of representatives of the Mississippi Chapter of the American Cancer Society, the Mississippi Tumor Registrars Association, the Mississippi Breast and Cervical Cancer Coalition, and representatives from the medical and surgical oncology and pathology communities, as well as from pathology/cytology laboratories. This group, which met for the first time on April 27th, will be closely involved in the planning and development stages. Reporting requirements have been presented to the Mississippi State Board of Health for adoption. A new Class III level of disease reporting has been created that will enable sources to submit reports on a quarterly basis. This will give the institutions time to complete their routine records and reports and still forward timely data to the MSDH. As with all other reportable diseases and conditions, strict confidentiality of personal identifying information will be enforced.

Uses of Cancer Registry Data

Annual reports of cancer data in the state will be distributed to all reporting sources, advisory group members, and other interested parties. It is anticipated that the first available full calendar year of data which conforms to the standards for completeness and timeliness will be 1996, which will be reported in 1997.

A statewide population-based cancer registry will allow for the first time accurate and complete cancer surveillance, and identify areas or population groups with excessive rates of cancers. Such data will be invaluable for statewide cancer control and prevention programs. For example, Mississippi is in the second year of a three year planning phase for the development of a Breast and Cervical Cancer Early Detection Program; data from the statewide central cancer registry will be the core component for surveillance in this control program.

The Office of Health Promotion and Education of the MSDH will be supplied with site-specific cancer data by geographic area (county), sex and race to assist in targeting health promotion and cancer prevention activities.

There is increasing public awareness of and concern over carcinogenic (or potentially carcinogenic) environmental and occupational toxins. Accurate population-based cancer incidence/prevalence data will identify occupations or industries which require further epidemiologic study, and allow evaluation of reported cancer clusters and proper response to the public.

Screening for various cancers (e.g. cervix, breast, prostate, colorectal) is becoming increasingly widespread. By monitoring the stages at which a tumor is first diagnosed, one can evaluate the needs and value of cancer

screening services, as well as help determine barriers to services and treatment.

The success of this new venture depends heavily on obtaining the full cooperation of all involved, particularly the reporting sources. To ensure this, the MSDH will be attempting to avoid, above all, placing extra workload and cost on these sources.

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Tennis Elbow

Larry D. Field, M.D.
Felix H. Savoie, M.D.

Tennis elbow, also known as lateral epicondylitis, represents a pathologic condition at the common extensor origin on the lateral humeral epicondyle of the elbow and is characterized by pain at the epicondyle. It is one of the most common injuries among workers, musicians and racquet sport athletes and occurs in over 50 percent of tennis players at one time or another in their careers.[4,6] The age of onset is generally after 30 years of age and most often around 40 years.

Etiology

Overuse Lateral Epicondylitis

Excessive use of the wrist extensors is clearly associated with development of tennis elbow.[9] The pathologic changes in the area of the extensor origin most commonly involve the extensor carpi radialis brevis muscle-tendon unit but such changes can occasionally be seen in the extensor digitorum communis, extensor carpi radialis longus and extensor carpi ulnaris. Repetitive microtraumatic injury due to intrinsic overload (overuse) leads to microtearing near the extensor origin. Repetitive injury and diminished vascularity result in fibrosis and granulation tissue production rather than a normal healing response. This process results in shortening of the muscle-tendon unit increasing the risk of reinjury. As this process continues, mucinoid degeneration of the tendinous origin results which leads to a vicious cycle in which the shortened, degenerative tendon is more easily damaged by any activity involving the arm. Less and less activity is required to produce damage to the tendon which results in further injury and inflammation to the tendon of origin, continued degeneration, and eventual failure of the tendon.

Traumatic Lateral Epicondylitis

One variant of tennis elbow that has received little attention is that initiated by a direct blow to the lateral aspect of the elbow. This traumatic variant differs from the overuse type of lateral epicondylitis in that the initiating event produces a direct injury to the bone of the lateral epicondyle as well as to the extensor tendon origin in this area. The damage produced to the bone, periosteum and tendon by this direct trauma results in localized necrosis in all three structures. Unlike the more common overuse syndrome, this injury may not respond well to nonoperative measures due to the injury to all three structures and often will require surgical repair. This makes identification of traumatic epicondylitis and differentiation from the overuse variant important.

Gross surgical inspection of the affected extensor origin reveals edematous , friable, grayish tissue which has lost the normal appearance of parallel fibers. Microscopic studies by Nirschl[7] reveal disruption of normal tendon fibers by fibroblastic invasion and vascular ingrowth referred to as angiofibroblastic hyperplasia. Regan et al.[8] in a histologic study of eleven patients with lateral epicondylitis and twelve cadaveric controls, demonstrated this vascular and fibroblastic proliferation and also identified local hyaline degeneration at the tendon origin. These findings were more suggestive of a degenerative process rather than inflammation. On this basis Nirschl[7] recommended the term "tendinosis" be used rather than "tendinitis".

Diagnosis

History

A patient with lateral epicondylitis will complain of pain at the lateral elbow exacerbated by resisted wrist extension. Morning stiffness along with aching throughout the day is common. The diminished blood flow to the injured area that occurs at night may result in moderate pain that awakens the patient and requires movement and icing to subside. Rest or avoidance of exacerbating events may alleviate some of the symptoms of lateral epicondylitis. However, as the extensor tendons are required to activate during almost any use of the hand, the patient will usually complain of pain even during normal daily activities such as in lifting a carton of milk.

Physical Exam

Examination of the elbow reveals tenderness approximately 2 mm anterior to the lateral epicondyle. This tenderness is exacerbated by resisted wrist extension with the elbow in approximately 20 degrees of flexion. In most cases, swelling or redness is not noted, but occasionally, a small defect in the extensor origin can be palpated.

The differential diagnosis of lateral epicondylitis would include posterior interosseous nerve entrapment[5] (radial tunnel syndrome), radiocapitellar degeneration, posterolateral rotatory instability and posterolateral plica syndrome. Rotation of the forearm while an axial load is applied will exacerbate the symptoms associated with radiocapitellar chondromalacia but should not exacerbate those associated with lateral epicondylitis.

Posterior interosseous nerve entrapment will produce a generalized soreness throughout the forearm with tenderness noted on direct palpation of the posterior interosseous nerve approximately 5 cm distal to the lateral epicondyle in the interval between the extensor digitorum longus and the brachioradialis on the dorsal radial side of the forearm. Radiating pain with resisted extension of the middle finger may also exacerbate symptoms associated with posterior interosseous nerve entrapment. It should be noted that in many cases, entrapment of the posterior interosseous nerve may co-exist with lateral epicondylitis and this entity should always be evaluated for in patients with lateral elbow pain.

Posterolateral rotatory instability is usually produced by a traumatic event and is the result of injury to the radial ulnohumeral ligament. This instability is often seen in post surgical patients with continued symptoms.

Posterolateral plica is simply an inflammation of the synovium along the lateral side of the elbow. It may co-exist with lateral epicondylitis or with any of the other described entities. This is best diagnosed by direct palpation that causes tenderness over the posterior aspect of the lateral epicondyle. Posterolateral plica syndrome often responds well to a direct injection into the inflamed area of the synovium.

Nonoperative Management

Patients presenting with lateral epicondylitis are best managed with a step-wise program to eliminate pain and increase the functional ability of the elbow. A discussion of the pathologic condition and the goals of treatment with the patient is an important part of nonoperative management. Such a discussion should focus on the poor healing response of these tissues following repetitive injury and degeneration.

Activity modification, protection of the lateral musculature with a cock-up wrist splint and counterforce brace, **(Figure 1)** nonsteroidal anti-inflammatory medications and rehabilitative exercises are used primarily during the initial treatment phase.



Figure 1: *Lateral elbow counterforce brace sometimes used as a component of tennis elbow rehabilitation.*



*Figure 2: Stretching exercises for the elbow flexor and extensor musculature. **A.** Flexor musculature stretching should be carried out with the elbow straight, maintained for 10 to 15 seconds, and repeated 5 to 10 times before and after each exercise session. **B.** Extensor musculature stretching should be carried out with the elbow straight, maintained for 10 to 15 seconds, and repeated 5 to 10 times before and after each exercise session.*

These exercises are designed to stretch the shortened musculotendinous unit and strengthen the surrounding musculoture while stimulating blood flow to the degenerative tissue near the lateral epicondyle **(Figure 2)**. Activity modification entails the reduction or avoidance of provocative activities if possible. As symptoms improve the use of braces and medication are gradually discontinued and the patient allowed to resume normal activities. A maintenance exercise program consisting of wrist extension exercises should be continued following recovery to prevent early recurrence of the symptoms.

For patients who do not respond to these interventions, a more aggressive program may be initiated. This program consists of the selected use of local corticosteroid injections along with supervised physical therapy sessions. The therapist's treatment goals should be to restore a normal and painless range of motion of the elbow, forearm and wrist by employing stretching exercises to the lateral musculature of the forearm along with a "four quadrant" wrist program so as to "rebalance" the musculature about the elbow. The selective use of modalities by the therapist such as direct friction and ice massage can also be beneficial.

Once full elbow and wrist motion are possible without pain or with only minimal discomfort, a coordinated rehabilitative exercise program is started.[1] Active wrist exercises are carried out initially without external resistance, including extension, flexion and circumduction. Forearm supination and pronation exercises are also performed. Isometric contractions in each of these forearm and wrist positions are subsequently added. Strengthening should then be advanced to include small (0.5 kg to 1 kg) weights or resistive rubber tubing and progress over a period of several weeks as tolerated **(Figure 3)**. After 4 to 8 weeks, strength and endurance have often returned to normal, and a regular strengthening regimen should continue in order to reduce the risk of reinjury. A resumption of work related activities or racquet sports participation can then be slowly reinstituted during the latter parts of the rehabilitative period with gradual progression to the preinjury level of functioning. Also, it is important for the patient to maintain rotator cuff and trunk strength throughout rehabilitation.

Equipment and tools can also have an effect on recovery. Tennis racquets with larger head sizes reduce arm vibration as do grip bands.[7] Reducing string tension and avoiding old balls with decreased bounce lowers energy transfer to the arm. When treating tennis players, once play has resumed considerations regarding proper tennis stroke technique are especially important toward promoting recovery and reducing the risk of reinjury. Properly coordinated motion of the trunk with the arm allows for maximum energy transfer at ball contact. This coupled motion reduces the demands on the arm by contributing the positive effect of trunk rotation to the stroke. Striking the ball while it remains in front of the body is also of value because it allows for effective forward thrust of the body which again serves to reduce the demands on the extremity.

Operative Treatment

Patients who have failed to adequately respond to all of these nonoperative measures and who are unable to tolerate the symptoms of lateral epicondylitis may be candidates for surgical intervention. Magnetic resonance imaging (MRI) can be helpful in selected cases in confirming the diagnosis and by determining the local extent of pathologic tissue.



Figure 3: Diagrammatic illustration demonstrating the strengthening exercises employed in tennis elbow rehabilitation.

Surgical Options

Surgical procedures for lateral epicondylitis can be divided into three groups. Group one involves the simple release of the pathologic tissue from the lateral epicondyle. This procedure can be accomplished either arthroscopically or through a percutaneous release. These techniques have the advantage of minimum morbidity and, in the case of percutaneous release, lower cost. They, however, fail to correct the primary pathology. The second group of procedures involves resection of the pathologic structures without any attempt at reconstruction. This requires an open procedure to excise the abnormal tissue. Such procedures again have the advantage of simplicity but the potential disadvantage of failing to correct the basic pathologic process. The third group of procedures are reconstructive operations that include excision of the damaged tendon, abrasion of the bone of the lateral epicondyle so as to stimulate vascular ingrowth, and tendon lengthening. These reconstruction techniques have the advantage of addressing all of the components of the pathologic process while restoring the anatomy of the lateral aspect of the elbow but have the disadvantage of being a more extensive surgical procedure.

Authors' Preferred Technique

We employ a technique that uses an incision extending from 1 cm proximal to the lateral epicondyle to the radial head distally. Following identification of the extensor aponeurosis a longitudinal incision through it and parallel to the skin incision is made. The underlying extensor carpi radialis origin is dissected free of the aponeurosis, and the tendon is examined for areas of mucinoid degeneration and scarring. Once this pathologic tissue is localized, excision is completed back to a perimeter of normal tendon. Decortication of the exposed

lateral epicondyle is also done to enhance postoperative healing. The bone of the lateral epicondyle is then perforated by using multiple small drill holes to establish channels for vascular ingrowth. The bone of the lateral epicondyle is then rasped down to a smooth surface to prevent any areas of impingement. The entire extensor retinaculum is then moved distally and closed using absorbable suture.

Postoperative Rehabilitation

The patient is placed in a soft dressing initially and started on immediate range of motion of the elbow. Progressive range of motion exercises are continued for approximately three weeks. Once painless range of motion is achieved, a strengthening program is initiated. Patients are usually allowed to resume normal activities between 3 to 6 weeks following surgery and are usually functioning at near normal levels by approximately three months postoperatively. Occasionally, the patient may require up to six months for full recovery from the procedure.

Results

In the past three years, the Mississippi Sports Medicine and Orthopaedic Center Upper Extremity Service managed 1,159 patients with lateral epicondylitis. Of this group, 160 patients underwent surgical intervention. One hundred thirty-eight of these patients were managed by open reconstruction and 22 patients underwent percutaneous release. All but one of the patients undergoing the reconstructive procedure have achieved a satisfactory result. The one patient with an unsatisfactory result utilized a chain saw five days following surgery which resulted in complete disruption of the repair necessitating a second surgical procedure. This patient subsequently developed a reflex sympathetic dystrophy in the elbow 6 months following the percutaneous release and continues to remain symptomatic. All 22 patients who underwent percutaneous release reported satisfaction with the index procedure.

The large majority of patients with chronic lateral epicondylitis can be successfully managed nonoperatively using these guidelines. When surgical intervention is necessary, satisfactory results can be achieved with a high degree of success.

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Larry D. Field, M.D. and Felix H. Savoie, M.D. are *Co-Directors of the Upper Extremity Service at Mississippi Sports Medicine and Orthopaedic Center in Jackson, Mississippi.*

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FOUNDATION FOR MEDICAL CARE

Management of Blood Pressure in Acute Stroke

Summary of A Mississippi Clinical Improvement Project

BACKGROUND

The American Heart Association (AHA) in 1994 released a clinical guideline entitled "Management of Patients with Acute Ischemic Stroke." The AHA guideline recommends that antihypertensive drugs should be withheld unless the calculated mean blood pressure is greater than 130 mm Hg or the systolic blood pressure is greater than 220 mm Hg.

When emergent blood pressure treatment is instituted, the best parenteral drugs appear to be those that are easily titrated and have a minimal effect on cerebral blood vessels, such as labetalol or Enalapril.

Sublingual use of a calcium antagonist such as Procardia should be avoided because of rapid absorption and secondary precipitous decline in blood pressure.

PURPOSE

- Establish baseline data on current practice and pharmaceutical agents used in the emergent management of blood pressure in acute stroke patients.
- Improve the treatment process of acute hypertension in acute stroke patients, particularly the pharmacological agents utilized.

METHODOLOGY

A random statewide sample of 545 patients discharged between May 1, 1993, and April 30, 1994, with a principal diagnosis of stroke was reviewed.

A Foundation abstraction tool was used to collect data on the emergent treatment of blood pressure, pharmacological agent chosen and route of administration.

FINDINGS

Emergent blood pressure treatment was ordered in 130 of the 545 charts reviewed representing 23.85% of the total. When emergent blood pressure medication was ordered, sublingual nifedipine (Procardia) was given 80.77% of the time. Labetalol was ordered 9.23% of the time.

Significant opportunities for improvement were demonstrated. The Foundation shared findings with providers in 1995. Thirty-four Mississippi hospitals are collaborating in this project. For more details, write to the Foundation for Medical Care, P. O. Box 4665, Jackson, MS, 39296-4665 or call 601-948-8894.



D. Stanley Hartness, Jr., MD

The President's Page

The Bottom Line

"How're you doing?" my elderly uncle asked as we greeted one another after the Sunday morning church service. My generic, familial "Fine" prompted his more specific, "How's your practice?"

The concern in his voice belied the innocuous nature of his question. It seems that the article "Gagging the Doctor" in his 1-8-96 issue of Time magazine and its cover story "Special Investigation: What Your Doctor Can't Tell You" in the 1-22-96 issue had struck a nerve. And a recent "20/20" segment on managed care elicited similar concerns from other patients.

At the heart of the matter for patients seems to be the freedom of choice of one's own physician. The physician patient relationship is the cornerstone of achieving, maintaining, and improving health. Although I cannot offer corroborating statistics from neat double-blind studies, the patient's perception that the physician-patient relationship itself has therapeutic value confirms what I have long contended.

Managed care would do well to recognize the cost effective competitive edge that a physician's knowledge of a particular patient's health history, the multidimensional aspects of that person's life, and the secrets that only a trusting patient reveals rather than regarding physicians and patients as faceless pieces of a health care puzzle that can be manipulated without consequences.

One of the most onerous aspects of managed care for physicians is the non-disparagement or so-called "gag" clause, a catch phrase for contract

provisions that fly in the face of "Patient Protection Acts". Examples of these "don't bad mouth the plan" rules include prohibition of discussing treatment options not covered by a plan or referring patients to specialists outside the plan. Some prevent physicians from revealing their financial relationship with a plan, especially when there are incentives to earn more for providing less care.

After these restrictions were decreed "not in the best interests of patients and physicians" by the December AMA House of Delegates, the AMA appealed our case to the media and to the marketplace, rather than risk legislative reform entangled in presidential politics and partisan posturing. And the message is finally being heard: Massachusetts banned gag clauses altogether while California and New Jersey are poised to follow. A New York physicians' group sued the state health commissioner for allowing gag clauses in managed care contracts.

But the biggest news came when U.S. Healthcare, a giant HMO covering more than 2 million Americans, recently revised its contracts to encourage physicians to talk to patients about medical options regardless of coverage.

Our Association' s 140th Anniversary Meeting scheduled for May 2-5 at the new Biloxi Grand Resort Hotel and Casino will provide a forum for managed care and other current medical practice issues. There will also be an opportunity to hear and discuss legislation of importance to our profession .

The bottom line becomes more than simple freedom of speech versus capitalistic freedom to profit. Rather, the bottom line reflects one of the most poignant questions a patient can ask of a physician: Who do you work for? Me or the insurance company's shareholders? The bottom line will ultimately remain in the black if our actions are determined by what is best for our patients and if we subscribe to the AMA's Code of Ethics which clarifies our absolute ethical obligation to put our patients first.

Stanley

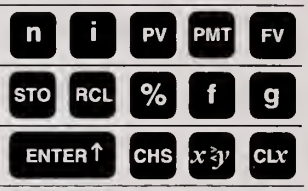
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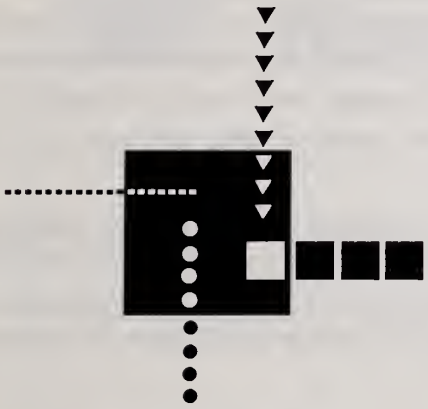
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Highlights of the June meeting include an information exchange, which builds on the December 1995, program theme, "Creating the Future and Getting There First." Physicians will:

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For more information, please call 800 AMA-3211 and ask for the AMA's Department of Organized Medical Staff Services.

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H. M. Fairchild, Philadelphia
Ira E. Gaddy, III, Gulfport
Delores E. Hatcher, Vicksburg
David D. Richardson, Jr, Jackson
Evelyn R. Walker, Jackson

DEATHS:

CARTER, WILLIAM L., JR., Meridian. Born Meridian, MS, May 17, 1925; MD Tulane University School of Medicine, New Orleans, LA, 1952; interned one year, Jefferson-Hillman Hospital, Birmingham, AL; internal medicine residency, Charity Hospital of Louisiana, New Orleans, LA, 1952 56; member of East Mississippi Medical Society; died January 19, 1996, age 70.

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Personals



*Nurse Mavis Barlow was honored by the House of Representatives with a resolution, introduced by **Jim Barnett, M.D.** of Brookhaven, for serving as the medical unit nurse of the State Capitol for 26 years.*

Dominic M. Cannella, M.D., announces the opening of his medical practice of Neurosurgery associated with Tupelo Neurosurgery Clinic.

F.H. (BUDDY) Savoie, M.D. was lecturer at the Arthroscopic Surgery Symposium held at Delta Whistler Resort in Whistler, BC. His topics were: 1)Wrist Arthroscopy - Advanced Procedures of the Elbow; 2)Triangular Fibrocartilage Surgery; 3) Arthrofibrosis - Arthroscopic Release; 4) Transglenoid Stabilization of the Shoulder; 5) Management of Multi-directional Instability of the Shoulder.

Alan E. Freeland, M.D., Professor of Orthopedic Surgery at the University Medical Center, was elected to a three-year term as treasurer of he American Association for Hand Surgery at the 26th Annul Meetng in Palm Springs, California.

Robert A. McGuire, Jr., M.D., Professor of Orthopedic Surgery at the University Medical Center, made a presentation at the North American Spine Society annual conference in Washington, D.C.

Roland P. Guest, Jr., M.D., FACC; Jack B. Foster, Jr., M.D., FACC; David H. Irwin, Jr., M.D., FACC; Michael J. Boland, M.D., FACC; Walter W. Woody, M.D., FACC and Allen Crow, Ph.D. have formed a new group with Cardiology Associates of North Mississippi. The Tupelo-based group is currently providing Cardiology services in the Heart Institute at North Mississippi Medical Center but will relocate to the newly constructed comprehensive Cardiology Center in the East Tower later this year.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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May 1-5, 1996
Grand Casino Hotel • Biloxi, MS

PROGRAM OVERVIEW

WEDNESDAY, MAY 1

1:00 PM	Exhibitor setup: Technical & Scientific
	MSMA Registration opens

THURSDAY, MAY 2

8:00 AM	Exhibits Open - Continental Breakfast
	MSMA Registration
	MSMA Reference Committee Breakfast
9:00	MSMA House of Delegates
11:00	Alliance Pre-Convention Board Meeting/Luncheon
11:30	MSMA Member/Exhibitor Lunch in exhibit hall
	Committee on Publications Luncheon
12:00	Young Physicians Section Luncheon
1:00 PM	MS Foundation for Medical Care Membership Meeting
	Preview Art Auction Items
2:00	MSMA Reference Committee on Constitution and Bylaws
2:45	MSMA Reference Committee A
4:00	MSMA Reference Committee B
6:30	MSMA/ MSMAA Membership Party

FRIDAY, MAY 3

7:30 AM	MSMA Members and Exhibitors Continental Breakfast
	MS EENT Association Breakfast/Meeting
8:00	MSMA Registration
	Alliance Registration
8:30	MSMA Medicine Plenary Session
	MSMA Past Presidents Breakfast
	MSMA Alliance Welcome & Coffee
9:00	MSMA Alliance House of Delegates
12:00 NOON	MSMA Alliance Luncheon
	MS Academy of Family Physicians
	MS Society of Addiction Medicine
	MS Society of Internal Medicine

FRIDAY, MAY 3 - Continued

1:30PM	MACM Golf Tournament - Edgewater Bay Golf Course
2:30	MSMA Alliance Post-Convention Board Meeting
5:00	MSMA Past Presidents' Reception
6:00	University of Mississippi Medical Alumni Association
7:00	MS Neurological Society
9:00	Southern Medical Assn. Ice Cream Party

SATURDAY, MAY 4

7:00 AM	Deep Sea Fishing
	MS Chapter, ACS, Officers and Board of Governor's Breakfast
8:00	MSMA Registration
8:30	MSMA Surgery Plenary Session
	MSMA Fifty Year Club Breakfast
	MSMA Alliance Past Presidents' Breakfast
12:00 NOON	MS Chapter, American College of Surgeons
	MS Chapter, American College of Emergency Room Physicians
	MS Association of Pathologists
3:00	MPIC - Annual Stockholders Meeting
3:30	Central Medical Caucus
6:00	MSMA President's Party

SUNDAY, MAY 21

7:30 AM	Membership Continental Breakfast
8:00	Protestant Services
9:00	MSMA House of Delegates
12:00 NOON	Meeting adjourns

EDUCATIONAL PROGRAM

PLENARY SESSION

Friday, May 3 • Room B

8:30 AM	**"Quality of Care Measurement"** Gerald Livandais, M.D., Medical Director Louisiana Care Review Organization
9:15 AM	**James Grant Thompson Memorial Lecture** **"The TN-Care Experience"** Henry G. Herrod, M.D., Professor of Pediatrics LeBonheur
10:00 AM	Break
10:20 AM	**"Mississippi Medicaid-Future Trends"** Helen Weatherby, JD, MPH, Director Mississippi Medicaid Program
11:00 AM	**"Defending a Liability Case - Dream or NightMare"*** Robert Jones, JD JoAnn Bienvenu, R.N. Medical Assurance Company of Mississippi (MACM)
	* Attendance meets requirement for MACM policyholders.
`Noon	**Adjourn**

PLENARY SESSION

Saturday, May 4 • Ballroom B

8:30 AM	**"The California Experience in Managed Care"** Eugene S. Ogrod, II, M.D., Chief Medical Director Sutter Medical Group
9:15 AM	**"Dakota Care - The Physicians' Plan for Managed Care"** Robert Johnson, CEO Dakota Care
10:00 AM	Break
10:20 AM	**"Primary Care Physicians in Mississippi - Current Trends"** David Lightwine, Branch Director Office of Rural Health, State of Mississippi
11:00 AM	**"Health Care Issues and the 1997 Congress"** Scott Wilber, Director AMA Washington Office
12:00	**Adjourn**

Plenary Programs Planned by MSMA's:
Council on Scientific Assembly

TECHNICAL EXHIBIT

MSMA 128th Annual Session

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Amgen, Inc.	8
American Medical Recruiting Co.	45
Bedsole Medical Companies, Inc.	30
BFI	29
Bristol-Myers Squibb	27
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Coastal Physician Services	20
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Mississippi State Medical Association Alliance

72th Annual Session
May 17-21, 1995
Treasure Bay Resort Hotel
Biloxi, MS

WEDNESDAY, MAY 17

3:00 PM - 5:00 PM	Registration - 2nd Floor Lobby

THURSDAY, MAY 18

9:00 AM - 4:00 PM	Registration - 2nd Floor Lobby
11:00 AM	Pre-convention Board Meeting/Luncheon - Magnolia
1:00 PM - 4:00 PM	Wine & Cheese - View AMA-ERF Auction Items - Alliance Suite
6:30 PM	MSMA/ MSMAA Membership Party & AMA-ERF Auction - Crystal Room

FRIDAY, MAY 19

8:00 AM - NOON	Registration - 2nd Floor Lobby
8:45 AM	Continental Breakfast - Crystal Room
9:00 AM	House of Delegates
12:00 PM	Luncheon/ Installation of Officers
2:30 PM	Post-convention Board Meeting & Workshop Sharon Scott, Presiding, "Transition of New Officers"

SATURDAY, MAY 20

8:30 AM	MSMAA Past Presidents' Breakfast - Crystal Room
10:30 AM	Brunch and Fashion Show
6:00 PM	MSMA President's Reception - Grand Casino Hotel, Biloxi

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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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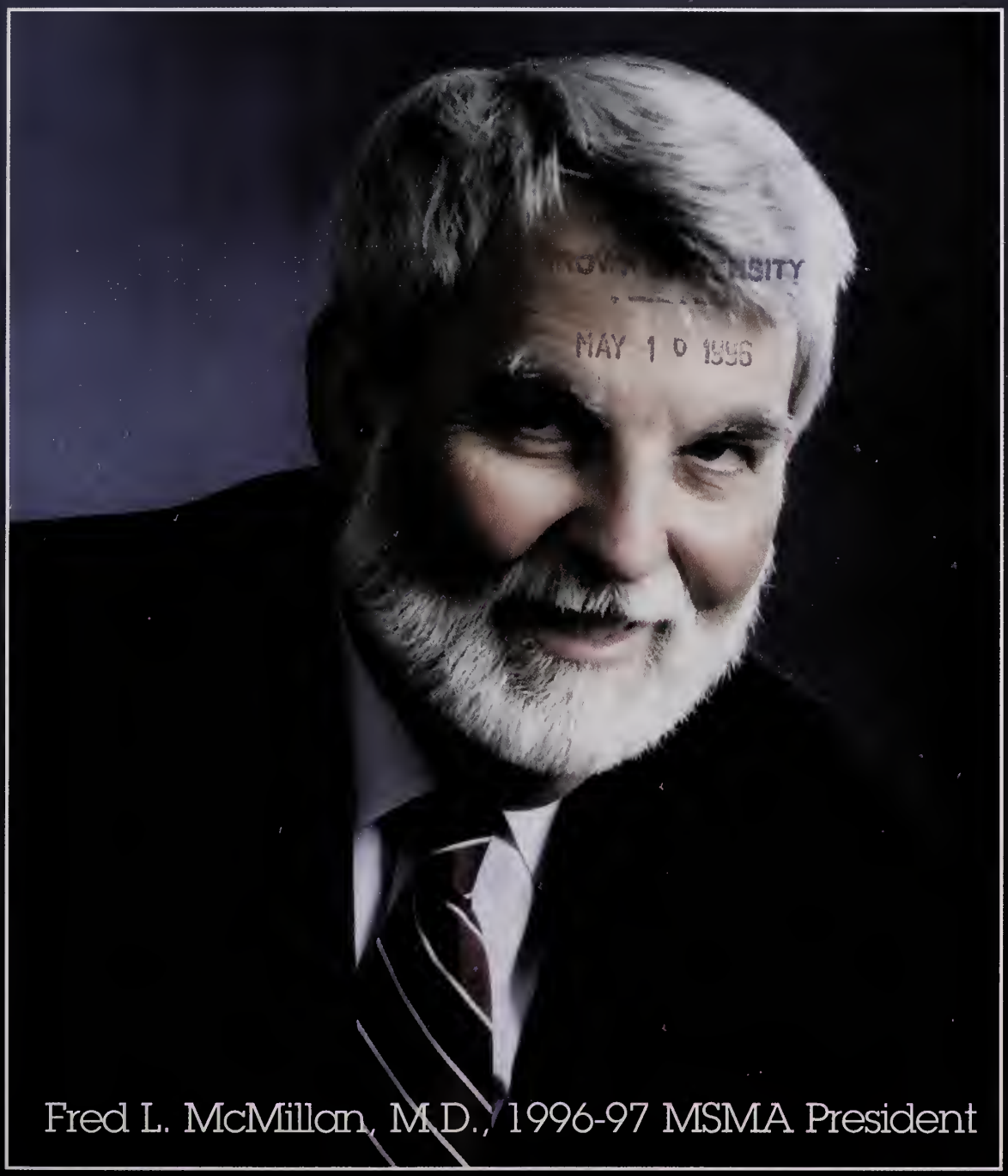
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JOURNAL

OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

MAY 1996


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Fred L. McMillan, M.D., 1996-97 MSMA President

WHEN A STROKE VICTIM IS COUNTING ON YOU, WHO SHOULD YOU COUNT ON?

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The most comprehensive stroke rehabilitation program in the state, offering specialized treatment for stroke complications such as aphasia, dysphagia and cognitive deficits.

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It's a proven fact. Stroke victims who begin a quality rehabilitation program early after a stroke are much more likely to return to rewarding lives than those who don't.

But there's one small hitch. Stroke victims are usually in no condition to choose where they are treated. More than likely, that critical task is up to someone like you. And in Mississippi, the place to choose when you want the best is Mississippi Methodist Rehabilitation Center.

Unlike other programs that offer limited rehab services, we're a comprehensive rehabilitation center with more than 20 years experience in stroke rehab. Our approach involves a complete, personalized program that treats every part of the patient that a stroke affects. And it includes everything from inpatient services to outpatient treatment, follow-up and home health services. Whatever it takes.

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For more information about our stroke rehabilitation and prevention program, call 1-800-223-6672 or 981-2611, ext. 3451.
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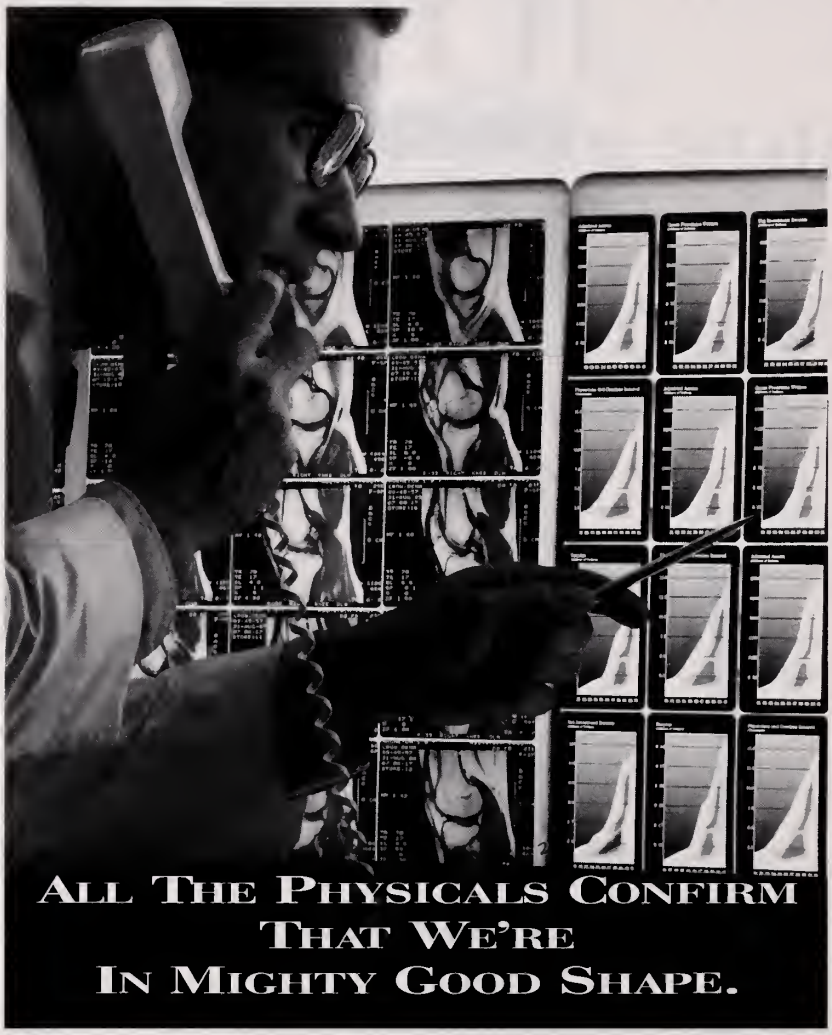
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Heart Failure: Epidemiology, Economics and Treatment

John B. O'Connell, M.D.
Charles K. Moore, M.D.

Introduction

Despite rapidly evolving therapies and interventions in cardiology and the wider application of primary and secondary prevention, cardiovascular disease remains the leading cause of death in the U.S., accounting for approximately 40% of the deaths annually. Cardiovascular disease accounts for at least 45% of the deaths in Mississippi, the third highest death rate in the nation.[1] In 1993 cardiovascular disease accounted for more deaths than all other causes (50%) in 16 (20%) of the counties in Mississippi.[2] However, both encouraging and discouraging trends related to this major public health problem are evolving. While the the mortality for myocardial infarction, a major cause of cardiovascular death, has declined by more than 30 percent since 1980, heart failure (HF) accounts for an increasing proportion of all cardiovascular deaths.

The development of more accurate diagnostic techniques and improved therapies over the past three decades has not resulted in an improvement in the two year mortality rate for HF which exceeds 50 percent.[3] The debilitating nature of this disease results in serious morbidity and poor quality of life in many of those who are afflicted over and above the adverse effect on survival. Although interventions to prevent HF are available for the two most common co-morbid conditions, ischemic heart disease and hypertension, aggressive blood pressure and lipid control has not been implemented to a degree sufficient to reduce the prevalence of heart failure. The purpose of this report is to review the epidemiology, economics and treatment of HF and discuss options for design of a cost-efficient system for managing these patients.

EPIDEMIOLOGY

Surprisingly, accurate information regarding the scope of the problem has not been compulsively tabulated. However, the National In-Patient Profile provided data by analysis of patient discharge records based on the International Classification of Disease, Ninth Revision (ICD-9) codes 428.0 (congestive heart failure), 428.1 (left heart failure) and 428.9 (heart failure).[4] Similarly, outpatient information was provided by the National Disease and Therapeutics Index.

The National Heart, Lung and Blood Institute (NHLBI) reported in 1990 that there were more than 3 million people in the U.S. with HF, more than 400,000 have newly diagnosed HF each year and 200,000 die annually with a cost of $8 billion per year.[5] Analysis of the above proprietary surveys over 1990-1991 confirmed

at least 3.5 million people in the U.S. with heart failure, 708,000 new patients diagnosed annually, and 280,000 annual deaths (Table I). As a result of the disproportion between the number of new diagnoses and deaths at least 400,000 more patients are added to the 3.5 million each year. Analyzing the expectations based solely on the increasing age of our population, the prevalence of HF is expected to double within the next thirty years. In 1990, there were 2.3 million hospitalizations (0.68/pt) at an average length of stay of 7.7 days including 3 days in intensive care units.

Table I - Epidemiology of Heart Failure in the United States 1990-1991

- Prevalence - 3,458,000
- New Diagnoses - 708,000
- Deaths - 280,000
- Hospitalizations - 2,280,425 (0.68/pt)
  - Length of Stay - 7.7 days (3 days ICU)
- Outpatient visits - 11,396,000 (3.4/pt)
- Total expenditure (estimate-non federal hospitals) > $36 billion.

Adapted from: O'Connell and Bristow (4)

The distribution of the HF population across the United States is similar with 913.5 discharges per 100,000 population (973 discharges per 100,000 population in the South; slightly higher than the national average). Urban non-teaching hospitals accounted for 39.6% of these discharges, rural hospitals 22.5% and urban teaching hospitals 37.9%. Although HF may develop at any age, it is largely a process in the elderly, with approximately 80% of discharges reported in patients older than 65 years of age, underscoring the financial burden carried by Medicare. More than one half of the discharges (54%) were noted in women, reflecting their higher proportion in the elderly population. Accurate information regarding racial distribution of HF is not available. However, the frequency is roughly proportional to the un(der)treated co-morbid conditions such as hypertension and diabetes, accounting for the disproportionately high prevalence reported in the Black population in some series.[6] Eight percent of the discharges resulted from death, 66% home or self care and more than 25% to various extended nursing facilities or home health agencies.

The NHLBI has identified that at any given time, 35% of patients are New York Heart Association (NYHA) Class I, 35% NYHA Class II, 25% NYHA Class III, and 5% NYHA Class IV. Therefore, the vast majority of HF care is provided in the ambulatory setting. In 1990, there were 11.4 million outpatient visits (3.4/pt) for HF.

EXPENDITURES FOR CARE

Accurate cost data are difficult to obtain and consequently have not been precisely tabulated. In an effort to estimate charges, a fictional 7.7 day hospitalization with three days in the Coronary Care Unit and conservative diagnostic evaluation and medical management was created for a HF admission at the University of Mississippi Medical Center.[4] The estimated total charge was $10,006 including professional fees (Table II). Using actual length of stay at the University of Colorado Medical Center in Denver, the charge for hospitalization was tabulated at $10,289 and in a small private hospital in Chicago's western suburbs using actual length of stay of 5.7 days, the charge was $10,600. The U.S. Battelle Medical Technology Assessment and Policy Research program calculated the average cost of a hospital stay for the SOLVD study at $10,770. Therefore, assuming the cost of hospitalization for HF is between $10,000 and $11,000 per admission and recognizing the 2.3 million admissions in 1990, the total cost in hospitalization for non-federal hospitals was at least $23.8 billion. Additionally, the Department of Veterans Affairs reports the cost of HF is their highest health care expenditure and in 1991 the Health Care Financing Administration, reported the inpatient cost for management of HF (DRG 127) exceeded the cost for treatment of all cancers and myocardial infarction.

Table II - Hospitalization Charges for Heart Failure

Institution	Charge*	Comments
University of Mississippi	$10,006	estimated LOS 7.7 days
University of Colorado	$10,289	actual LOS 6.3 days
Alexian Brothers Medical Center (Elk Grove Village, IL)	$10,647	actual LOS 5.7 days
US Batille Medical Technology - Assessment and Policy Research (from SOLVD)	$10,770	
Average	$10,428	

LOS = length of stay; SOLVD = Studies of Left Ventricular Dysfunction

* includes professional fees and ancillary services

A similar calculation was made for ambulatory care with conservative oral medications (digoxin, 0.25 mg/d, furosemide 40 mg/d, warfarin 5 mg/d and enalapril 5 mg BID), chemistries, non invasive testing annually and professional fees. The total charge per patient was estimated at $3,449 which when extrapolated to the 3.5 million patients with HF totals almost $12 billion. The cost of cardiac transplantation, the most individually expensive of all therapies but limited in scope of application, was $270 million. The total cost for all HF management was at least $36 billion in 1990, representing > 5% of U.S. health care dollar expenditure.

TREATMENT

The rising prevalence, excessive cost, and high mortality of HF mandate that new therapies be aggressively sought and applied. Restriction of salt and water continues to be a very important component of treatment of HF (Table III). However, recently activity recommendations have changed. In fact, regular aerobic exercise such as walking, cycling, swimming or jogging, should be encouraged in patients with stable NYHA Class I - III HF. The conditioning that results from regular exercise usually improves exercise tolerance. Isometric exercise such as weight lifting, should be discouraged.

Table III - Treatment of Heart Failure with Systolic Dysfunction

- Sodium and water restriction
- Regular aerobic exercise within symptomatic limitations
- Angiotensin converting enzyme inhibitors
- Diuretics
- Digitalis glycosides

Conventional medical treatment of heart failure with systolic dysfunction consists of angiotensin converting enzyme (ACE) inhibitors, diuretics and digitalis glycosides. Because survival data are not available, diuretics remain purely symptomatic therapy for HF. Over the last twenty years debate regarding the efficacy of digitalis glycosides in chronic HF and sinus rhythm has developed. Recently, two clinical trials with similar designs (RADIANCE AND PROVED) demonstrated that withdrawal of digitalis glycosides from stable patients resulted in clinically-relevant deterioration.[7,8] The economic implications of these digoxin withdrawal studies were analyzed and it was estimated that 185,000 clinic visits, 227,000 emergency department visits and 137,000 hospitalizations for heart failure could be avoided simply by maintaining all patients on digoxin.[9] The net annual savings (assuming a + 33%/year digoxin toxicity rate) is estimated at $406 million. These studies only analyzed morbidity. The effect of the routine administration of digoxin on mortality of administration of digoxin on mortality of HF is currently under clinical investigation.

Angiotensin converting enzyme inhibitors were approved by the FDA for the treatment of heart failure based on the hemodynamic benefit and improved exercise tolerance. [10] However, the results of the Cooperative North Scandinavian Enalapril Survival Study (CONSENSUS) in which NYHA Class IV patients with HF were randomized to receive enalapril or placebo in addition to conventional treatment emphasized the true importance of ACE inhibition.[11] This study was originally designed to enroll 500 patients over five years. At the end of one year follow-up and randomization of 253 patients, the Data and Safety Monitoring Board stopped the trial due to a 30% reduction in mortality in the patients receiving enalapril. In the Studies of Left Ventricular Dysfunction (SOLVD) in the U.S., a less severely symptomatic HF population with demonstrable systolic dysfunction were randomized to placebo or enalapril .[12] More than 2,600 patients were followed four years and a significant reduction in mortality was noted in those patients receiving enalapril. In the second Vasodilator Heart Failure Trial (V-HeFT II) of 804 patients followed four years, administration of enalapril resulted in a greater than ten percent reduction in mortality risk compared to patients treated with the previously successful combination of hydralazine and isosorbide dinitrate.[13] These trials emphasize importance of ACE inhibition for prolongation of life rather than solely symptomatic relief. The observation that the improvement in ejection fraction with enalapril was inferior to hydralazine/isosorbide dinitrate suggests that the mechanism of the survival benefit of ACE inhibitors extends beyond the hemodynamic effects.[13] Ventricular remodeling, i.e., the geometric change resulting from myocardial injury and increased afterload and preload, may be deleterious and enhance the likelihood of heart failure. It has been postulated that activity of the myocardial angiotensin converting enzyme and subsequent activation of the AT-1 angiotensin II receptor results in release of local/growth factors (paracrine function) that stimulate interstitial fibrous proliferation as well as myocyte hypertrophy, augmenting remodeling.[14] Consequently, ACE inhibitors function as considerably more than vasodilators when treating cardiac disease. In that light, the Survival and Ventricular Enlargement Trial (SAVE) evaluated the use of captopril in 2,231 patients within the first week of acute myocardial infarction who had an ejection fraction < 0.45.[15] Over a four year follow-up, a 19 percent reduction in mortality was detected in those who received

ACE inhibition. Moreover, a significant reduction in the likelihood of development of symptomatic HF and the number of hospitalizations for HF was documented in those receiving captopril. In the prevention arm of SOLVD, 4,228 patients with asymptomatic left ventricular dysfunction, i.e. NYHA Class I, and left ventricular ejection fraction <0.35 were randomized to enalapril or placebo and followed four years.[16] Although a trend (p=0.12) for reduction in mortality in the enalapril-treated group was detected, the primary endpoint for the Trial was development of heart failure and consequently, the sample size necessary to resolve the survival issue was not achieved. However, a 37% reduction in the risk of development of HF, a 36% reduction in first hospitalizations for HF and a 44% reduction in multiple hospitalizations for HF were noted in the enalapril-treated group. One life was saved for every 300 patients treated per year and three episodes of HF were prevented for every 100 patients treated per year. The above studies indicate that ACE inhibition should be administered to all tolerant patients with left ventricular systolic dysfunction even when asymptomatic.

Anticoagulation was recommended until recently for all patients with ejection fractions below 0.20-0.30 to prevent systemic embolization. However, this recommendation was not based on randomized prospective trials and retrospective analyses do not justify the routine administration of anticoagulants. Therefore, anticoagulation is recommended only in patients with a history of systemic or pulmonary embolization, recent atrial fibrillation or mobile intracardiac thrombi.

Antiarrhythmic therapy should never be considered in patients with symptomatic ventricular arrhythmia and HF, since more than 70% will have non-sustained ventricular tachycardia.[17] Most antiarrhythmic agents have negative inotropic and chronotropic effects which will exacerbate heart failure symptoms. Additionally, potential proarrythmic effects may convert a benign into a life-threatening arrhythmia. Amiodarone appears to be the safest of all antiarrhythmic agents in this setting. However, in the CHF-STAT Trial, administration of amiodarone did not reduce the likelihood of sudden death even when the arrhythmia was successfully suppressed.[18] The implantable cardioverter/defibrillators (ICD) have been inserted in patients with HF. However, prospective study of prevention of death has not yet been reported in this population.

When conventional medical management does not control the symptoms of heart failure and the patient is on an escalating medical regimen with recurrent hospitalizations or is requiring intravenous inotropic agents, cardiac transplantation should be considered in patients under 65 years of age.[19] Improved immunosuppression with more specificity has allowed successful transplantation across previously insurmountable barriers, allowing access to a more diverse population. Most patients return to a symptom-free functional life following cardiac transplantation and survival at one year exceeds 80% with a ten year survival rate of 50-70%.[20] At this time, an insufficient donor supply prevents immediate access for most eventual recipients and consequently, the national median wait exceeds 200 days. In Mississippi, where the demand to availability ratio is more favorable, the median wait approximates 50 days. Alternatives to cardiac transplantation are being developed including totally implantable mechanical circulatory assistance, dynamic cardiomyoplasty and xenografting (transplanting across species).

The future is even brighter for medical management of heart failure (Table IV). Following the initial retrospective description of reduced mortality in patients with HF and dilated cardiomyopathy, the literature has been replete with convincing studies demonstrating hemodynamic benefit and improved functional performance and quality of life following chronic administration of beta-blockers.[21,22] The Beta-Blocker Evaluation Survival Trial (BEST) is designed to determine whether chronic administration of bucindolol will reduce mortality.[23] Furthermore, vesnarinone and the related OPC 18790, have shown encouraging results demonstrating a 62% reduction in mortality in the initial clinical trial.[24] These drugs possess phosphodiesterase inhibiting as well as sodium and potassium channel blocking properties. Placebo controlled trials designed to verify these encouraging initial results are in progress. Additionally, angiotensin II receptor (AT 1) blockers are in clinical trials for HF. Access to these medications can only be provided by designated centers for study such as the University of Mississippi Medical Center Heart Failure Treatment Program.

STRATEGIES TO OPTIMIZE CARE

Heart failure is a disease which is by and large managed by primary care physicians. Only 24% of patients with heart failure cared for in 1990 were followed by a cardiologist.[24] To optimize accessibility to treatment, a two-tiered system must be developed. As the first tier, emphasis must be placed on maximizing conventional medical therapy and accentuating care in the more cost-efficient ambulatory setting to reduce the excessive economic burden of hospitalization. Extensive patient education and home health programs must be established and physicians who are knowledgeable in conventional man-

agement should establish clinical protocols to follow these patients closely. Integrated outpatient management programs for heart failure have been established for the managed care environment and have projected annual savings of approximately $4,000 (36% of current cost) per patient.[28]

When a patient has received maximal ACE inhibition and remains symptomatic, referral to a comprehensive heart failure center, the second tier in the system, should be considered. The comprehensive heart failure treatment center should have a large regional referral base with strong, nationally recognized leadership and committed faculty. The Center should have access to experimental therapeutic agents, the capability to provide cardiac transplantation and mechanical circulatory assistance, the support of basic and clinical research programs and the capability for advanced fellowship training. Such a program has been established at the University of Mississippi Medical Center.

Table IV - Experimental Drugs in Clinical Trials for Heart Failure

- Beta blockade - bucindolol, carvedilol
- Vesnarinone, OPC 18790
- Angiotensin II receptor (AT-1) blockade

CONCLUSIONS

Heart failure continues to escalate in importance as a major cause of morbidity and mortality. The recently implemented conventional treatment of heart failure improved survival over previous therapies, but is suboptimal in that many patients continue to deteriorate. Cardiac transplantation is a viable therapeutic alternative, and several new medications that may improve survival and quality of life are on the horizon. Access to these therapies should be available to all patients, and the health care delivery system should be organized to efficiently provide care to the population that it serves. ❑

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News

Local Coalition On Donation Formed

In January, 1996, a group of local agencies formed an alliance to promote organ and tissue donation in Mississippi. The formation of this alliance was spearheaded by the Mississippi Lions Eye and Tissue Bank and Mississippi Organ Recovery Agency. The group of agencies will be known as the Mississippi Donor Network. It is one of 69 such groups from across the United States that have formed to work with the Advertising Council Inc., through the aegis of the National Coalition on Donation to increase donation through public education efforts.

In 1993 the National Coalition on Donation and the Advertising Council selected the platform of organ and tissue donation from over 400 applications. The American Medical Association, American Society of Nephrology, American Society of Transplant Physicians, American Society of Transplant Surgeons, American Diabetes, American Heart, and American Hospital Associations as well as select pharmaceutical companies comprise some of the 48 members of the National Coalition on Donation. The Advertising Council is the not-for-profit Council is the group of advertising industry volunteers who lend their services free of charge to develop highly visible and enduring education campaigns on national issues. Some of the Ad Council campaigns in the past have been Smokey Bear, Buckle Up, and War Bonds.

The theme of the national organ and tissue donation campaign is "Share your life. Share the decision," with the intended take away of the advertising message being: "To be an organ donor, even if I've signed something, I must tell my family *now*, so they will know to carry out my decision later." The mission is to ensure that every individual in the U.S. understands the need for organ and tissue donation and accepts donation as a fundamental human responsibility.

A series of broadcast and newspaper public service announcements (PSAs) have been released in the Mississippi market. A follow-up advertising and marketing campaign endorsed by national basketball celebrity Michael Jordan is also available for sponsorship.

The following agencies are members of the Mississippi Donor Network: Mississippi Lions Eye and Tissue Bank, Mississippi Organ Recovery Agency, Mississippi State Medical Association, Mississippi State Department of Health, University of Mississippi Medical Center (UMMC), WTYX- Radio, International Family Entertainment-Cable Network, WLBT-TV3, Junior League of Jackson, Mark E. Seepe Funeral Directors & Crematorium and the Mississippi Chapter National Kidney Foundation. The January 25, 1996 Donor Network meeting marked the formation of Mississippi's first official organ and tissue procurement organization outside of the UMMC. For more information about the Mississippi Donor Network, or if you would like to become a participating member, call 933-1000 or 1-800-362-6169.

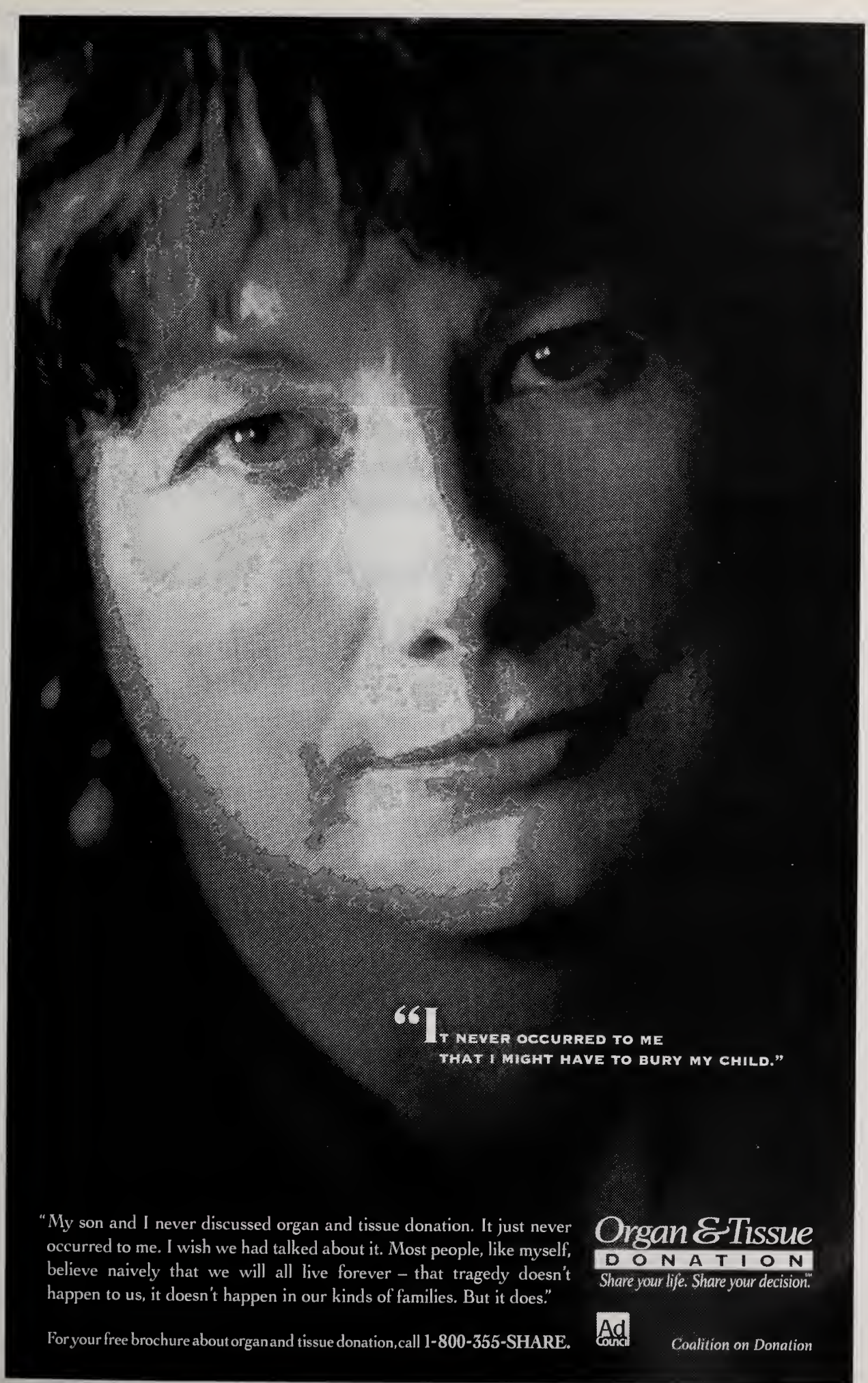


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Peritonsillar Abscess Following Tonsillectomy

C. Ron Cannon, M.D.
Lucius M. Lampton, M.D.

Abstract

Peritonsillar abscess is an unusual complication following tonsillectomy. A series of five such patients is herein reported. Proper treatment begins with the initial tonsillectomy ensuring complete removal of the tonsils. Should a late peritonsillar abscess following tonsillectomy be found, the patient may be treated with needle aspiration of the affected area plus antibiotics. Removal of the remaining tonsillar tissue and surgical capsule of the tonsil is also advocated.

Introduction:

Tonsillectomy is a common procedure in Otolaryngology-Head and Neck Surgery Studies list it as the eighth most commonly performed surgical procedure in the United States.[1] Although tonsillectomy is considered a safe procedure, complications may occur. Such hazards as soft tissue, dental, and vertebral trauma, bleeding, and infection are usually readily recognized. Peritonsillar abscess, however, is seldom thought to be related to a previous tonsillectomy. The authors report a series of 5 patients who developed a peritonsillar abscess as a late complication of their tonsillectomy.

Materials/Methods:

A retrospective review of 1501 patients undergoing surgery for tonsillar disease at the Head and Neck Surgical Group (Jackson, MS) over a 11.5 year period was carried out. Five patients were identified who were treated for peritonsillar abscesses following tonsillectomy (Table 1). In none of the cases had the patients undergone their initial surgery at the Head and Neck Surgical Group.

TABLE: Patients with Peritonsillar Abscess Following Tonsillectomy

PATIENT	AGE	SEX	DATE OF INITIAL TONSILLECTOMY	PREVIOUS SYMPTOMS OF TONSILLITIS	SITE	TREATMENT
1	27	F	age 17	No	Left	Admitted to hospital for antibiotics acutely Excision tonsil capsule tag one month later
2	32	F	age 5	No	Left	Fine needle aspiration plus antibiotics
3	14	F	young child	No	Left	Excision tag capsule acutely
4	26	M	young child	No	Right	Fine needle aspiration plus antibiotics
5	20	F	age 2	No	Right	Excision tag capsule acutely

The ages of the patients ranged from 14 to 32 years. There were 4 females and 1 male. All of the patients in the group had undergone tonsillectomy during childhood. All presented with an acute sore throat. On examination, all had swelling and edema in the superior tonsillar area. In none was there evidence of parapharyngeal or retropharyngeal abscess. The left peritonsillar area was affected in 3 patients while the right side was affected in 2. In none of the patients was there a significant history of tonsillar infections from the time of their initial tonsillectomy to the onset of their peritonsillar abscess. All of the patients were treated with antibiotics initially. Two underwent drainage of the abscess by a fine needle aspirate technique. The other three underwent excision of the tonsillar capsule (Figure 1). Two of these were done acutely (Figure 2), the other in an interval fashion one month post treatment of her peritonsillar abscess. None of the patients has had recurrent problems in up to 8 years follow-up.

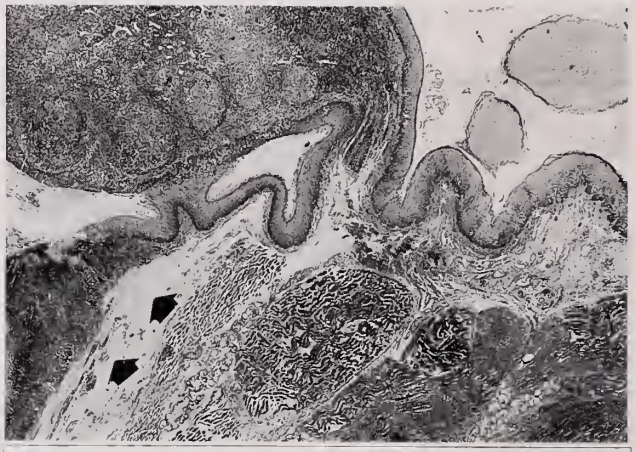


Figure 1: *Remnant of tonsillar tissue with surgical capsule(arrows) H & C, 40X.*



Figure 2: *CT scan of left peritonsillar area demonstrating edema and fluid density(arrow) in the region of the superior tonsillar area(Patient 3).*

Comment

Most patients with peritonsillar abscess have been described as being young with a recent history of acute tonsillitis.[2,3] The patient usually complains of severe sore throat, ipsilateral otalgia, trismus, and inability to control their oral secretions. Peritonsillar abscess is most often unilateral, although bilateral cases have been described.[4,5,6] Peritonsillar abscess is only rarely thought to be related to a prior tonsillectomy. A review of the literature disclosed only two series of patients developing peritonsillar abscess following tonsillectomy.[7,8] In the larger series 4 patients had undergone tonsillectomy during childhood for tonsillitis. Three patients were asymptomatic until developing abscess. One patient had symptoms of tonsillitis for six months prior to development of a peritonsillar abscess which had followed a Quinsy tonsillectomy performed seven years earlier. In the present series, none of the patients had episodes of tonsillitis from their initial tonsillectomy to the development of their peritonsillar abscess.

The anatomy of the tonsil may well be a causative factor in the development of these late peritonsillar abscesses. Although the tonsil clinically does not have a true anatomic capsule, the tonsil does possess a surgical capsule.[9] This surgical capsule, termed the pharyngeal fascia, encloses consists of areolar tissue, which separates the tonsillar tissue from the palataglossus and the palatopharyngeus muscles. The areolar tissue can be split into layers superiorly. This may account for the development of peritonsillar abscesses in the superior pole of the tonsil. At the time of initial tonsillectomy, if particular care is not exercised in the superior pole of the tonsil in developing proper plane of dissection, tonsillectomy will be incomplete. This remaining portion of the superior surgical capsule may then provide the nidus of a future peritonsillar abscess.

The treatment of peritonsillar abscesses is somewhat controversial: some advocate medical treatment while others advocate tonsillectomy.[10,11,12,13,14] The current

trend is toward acute surgical treatment, i.e. incision and drainage plus tonsillectomy, sparing the patient an interval procedure six weeks later. Should surgical treatment be performed, care should be taken that all remnants of tonsillar tissue and remaining capsule are completely removed. Patients who are poor surgical risks or who decline surgery may be adequately treated by fine needle aspiration of the affected area and appropriate antibiotics.[15]

Summary:

Peritonsillar abscess may develop as a late and serious sequelae of tonsillectomy. Proper management begins with the initial tonsillectomy by ensuring complete removal of tonsillar tissue, especially the surgical capsule. Particular care should be taken in initiating a proper plane of dissection in the superior pole of the tonsil. Should a patient be encountered with post-tonsillectomy peritonsillar abscess, appropriate treatment is needle aspiration and antibiotics or excision of the persistent tonsillar tissue and capsule. ❑

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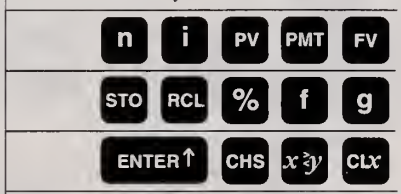
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Fred L. McMillan, M.D.

The President's Page

If It Is To Be -It Is Up To Me

The health care delivery system in the U.S. is undergoing reform, an upheaval of reform equal to an 8.1 on the Richter scale. We as physicians have coped with the technologic and pharmacologic advances easily because our training in "med school" and residency prepared us for this. We knew that when we started practice we "had to keep up" with the advances in medicine or "fall behind".

What we did not know (though all our successful contemporaries in the business world knew) was that we "had to keep up" with the changes in the business side of medicine or "fall behind". Therefore, we find ourselves caught in the headlights of the oncoming train of health system reform. Those that are not able to adapt will take early retirement, a desk job, or bankruptcy. Those that do adapt will realize the sky is not falling and will be able to separate the practice of the science and the art of medicine, with all of its rewards, from the practice of the business of medicine with its rewards.

How then do we cope with this unpreparedness for the business of medicine? First, get out of the headlight. No, don't try to bury your head in the asphalt--look in any direction other than at the "bad news". Your MSMA, your AMA and your specialty society are affecting change by providing leadership, being our spokesmen and providing mechanisms for us to ride this wave of change...

•Clinton's onerous health plan did not survive because of the lobbying of these organizations.

•Slow inroads are being made legislatively in tort reform and anti-trust regulations.

•Physicians have ownership in a managed care network-MPCN, a PRO company- MFMC, a medical liability company-MACM, etc.

What physicians need is the input of all our voices. Like boiling water, reform comes from the bottom up. So must medical reform come from the grassroots of our profession. Like the false perception- the watched pot takes longer to boil; also false is the perception "nothing I can do about it".

I sought leadership roles in medicine for several reasons. First, to learn what is happening to, and within medicine. Second, to actively participate in the dialogue and decision making process in organized medicine. Third, and most importantly, to give back to medicine. The profession of medicine has had a wealth of respect and opportunity deposited in it by those who have come before us. We have benefited from that, and we need to continue in that tradition being sure to add more to the bank than we withdraw. I ask all of you to assess your deposits and your withdrawals. Be sure your balance is in the black. If you feel you are close to a negative balance, get involved locally, statewide, and nationally, not only for yourself and your colleagues, but also for those who will come after us. Bring others along into active involvement in organized medicine. Not sure where to start? Contact your local leadership, your trustee, your MSMA staff, or me.

As an executive replied when asked what her formula for success was, "It's very simple," she said, "Just ten simple two-letter words: 'if it is to be, it is up to me'."

Fred

WHEN YOU NEED TO BE SEVERAL PLACES AT ONCE, ISN'T IT A RELIEF TO KNOW YOUR BANK WILL BE THERE, TOO?

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Editorial

JOURNAL OF THE
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"FISCHERISMS"

Recently I entered the Ripley Public Library to find Tommy Covington, our beloved librarian and literary mogul, standing among hundreds of immense tomes of timeworn medical texts.

My curiosity was overwhelming. He related how an older physician who practiced out of state for many years had moved back to his Tippah county home place to retire. When circumstances necessitated yet another move, he was inspired to give his entire collection of books to our local library. Goody for us. Though pleased with his generous donation, I still can't imagine ever giving all my books away. My books are like my feet, the more formidable they become, the broader is my base and I don't go anywhere without them. If my house was on fire, my books would be the first material possessions I would try to salvage.

Tommy found among the monographs and manuals, tracts and treatises, a tiny hard-bound volume entitled ***Fischerisms***. There were two identical copies and he asked if I would like to have one. He might as well have asked if I'd like to have a diamond ring.

As stated on the Frontispiece, ***Fischerisms*** is a "sheaf of sundry and divers utterances culled from the lectures of Dr. Martin H. Fischer, professor of physiology in the University of Cincinnati." It is a simply delightful volume of aphorisms... "terse, pithy statements" collected from the margins of the notebooks of his physiology students during "moments of abstraction among the pen-and-ink Masterpieces of women and beer Seidels."

Two of his students, Howard Fabing and Ray Marr, compiled and published Dr. Fischer's bits of wisdom in 1930.

Fabing wrote, "You taught us the physiologic concepts of the times and we shall try to apply them in the solution of the riddles of clinical medicine. But in the years to come, when our academic enthusiasms shall have paled into the drabness of a day's routine, the spirit behind them will continue within us. Those phrases which laid men's souls open for dissection, those bolts of truth which shook our foundations, the daily challenges hurled to make us thinking individuals rather than standardized hawkers of wares, the constant plea that we carry ourselves as honorable men in an honorable profession--these arrows struck deep....They have become a lasting spur toward higher attainment in the profession you have taught us to respect and love."

Since the days of Hippocrates the aphorism has been the prevailing literary vehicle of the physician. Laymen have stolen our trick from time to time, but the aphorism remains the undisputed contribution of the doctor to literature. Here, for your enjoyment, are just a few "Fischerisms".

•Observation, Reason, Human understanding, Courage; these make the physician.

•The benefits of medicine are not to be found in standards appreciated by the masses.

•A doctor is a man possessed of such qualities that people turn to him instinctively to help them solve their problems, both material and immaterial.

•A doctor must work eighteen hours a day and seven days a week. If you cannot console yourself to this, get out of the profession.

•Expect an early death - it will keep you busier.

•Only one rule in medical ethics needs concern you--that action on your part which best conserves the interests of your patient.

•Believe in the reasonable decency of the brethren; patients are not stolen - they run away.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

•You can't go out and teach a community to think clearly if you can't think clearly yourself.

•This is the trouble with us doctors: our talk is sloppy, like the preachers' - and the result is bad for both professions.

•If you do not agree with the prevalent point of view, be ready to explain why.

•Someone has said: A conclusion is the place where you got tired thinking.

•Knowledge is a process of piling up facts; wisdom lies in their simplification.

•Principles are the important things; the more you have of them, the more knowledge can you carry.

•The doctor must set the example for the community; he must command respect and awe; he must be a god, in other words.

•Be a god to the outside, but not to yourself. Don't wobble outside, wobble inside.

•Whenever ideas fail, men invent words.

•We die of the things we know nothing about.

•When there is no explanation, they give it a name, which immediately explains everything.

•None of the great discoveries was made by "specialists" or "researchers".

•In diagnosis, think of the easy first.

•If your diagnosis is wrong, you're ruined-because the patient never forgets; but if your diagnosis is right, you're also ruined-unless you forget.

•Don't cry out against the quack; find out wherein his success lies-and be a better quack.

•You have allowed the drug hawkers, the cosmeticians, the masseurs and the colon flushers to run off with the major portion of your practice-treatment.

•A patient comes to see you. When you believe that an assistant can do your job as well, you are on the way out.

•Life is a ticket to the greatest show on earth. As a doctor you'll have a front seat.

•Nihil humanum alienum mihi putet, which is just another way of saying you cannot be surprised.

•To be surprised as a doctor is to be ignorant, intolerant, or an ass from the cornfields.

•A flustered doctor is the most useless and despicable of men.

•Diagnosis is not the end, but the beginning of practice.

•In the sick room, ten cents' worth of human understanding equals ten dollars' worth of medical science.

•When you no longer know what headache, heartache, or stomachache means without cistern punctures, electrocardiograms, and six x-ray plates, you are slipping.

•When in doubt as to which disinfectant to use, try soap and water.

•Someday, when you have time, look into the business of prayer, amulets, baths and poultices and discover for yourself how much valuable therapy the profession has cast on the dump.

•A man who cannot work without his hypodermic needle is a poor doctor. The amount of narcotic you use is inversely proportional to your ability.

•I feel sorry for you, Boys! We used to learn our therapy from a professor. Now he disparages the subject and you learn it from the drug house or a radio.

•Half the modern drugs could well be thrown out the window, except that the birds might eat them.

•Doctors don't spend enough time with their patients and don't do enough of the medical slop.

•There are far too many nurses and housemen about.

•No third person may stand by when the doctor converses with his sick.

•The last elements of practice can never be taught you. The disciples did not wholly comprehend Jesus, you know.

•The public blabbers about preventive medicine, but will neither appreciate nor pay for it.

•You get paid for what you cure.

•Better learn physiology! For when the preventive medicine boys have conquered, only physiology will be left.

•The big problems of medicine will be solved by young men. Young men always do it. They are uneducated and therefore unprejudiced.

•Education is the process of driving a set of prejudices down your throats.

•Education! Why say it is a stimulant when it has become a narcotic?

•It is not hard to learn more. What is hard, is to unlearn when you discover yourself wrong.

•Do not sacrifice a large good for a little evil.

•Modern education is a mess. We do not learn for keeps. We do not correlate nor do we pyramid our facts. We do not teach the how and why, but rather the what- which is always changing.

•Even an ass can die with a degree. All it takes is four years and four thousand dollars.

•A good teacher must know the rules; a good pupil, the exceptions.

•As prosperity is promoted, thinking is demoted.

•Standardization is the fertilizer of university education. A little may be useful, but flowers do not grow in pure manure.

•Hysteria is the result of bad education.

•All the world is laboratory to the inquiring mind.

•The great doctors all got their education off dirt pavements and poverty-not marble floors and foundations.

•Don't despise empiric truth. Lots of things work in practice for which the laboratory has never found proof.

•You must learn to talk clearly. The jargon of scientific terminology which rolls off your tongues is mental garbage-just a string of five-dollar words which you use without understanding.

•Stop telling men not to worry; all thinking men do; and such only do the world's work.

•The great man is he who sees the mundane with uncommon eyes and imagination.

•The great man is the man who has the courage to act.

•When you say a man has guts, you say he has a soul.

•I like men who can withstand circumstance. That's why I love buzzards.

•Our profession is the only one which works unceasingly to annihilate itself.

•While Rome burns, it is better to fiddle than wring your hands.

•The minister sees them half undressed; the doctor sees them naked. They lie to the minister; they masquerade before the lawyer; but they cannot deceive the discerning physician.

•In my experience no good doctor was ever asked long to stay hungry, cold or unliquored.

•We are all parasites; we humans, the greatest.

•Bacteria keep us from heaven and put us there.

•The tears of the yellow, black, brown, and white man are all the same.

•Of course I teach you only the truth-but that shouldn't make you believe it.

•First need in the reform of hospital management? That's easy! The death of all dieticians.

•Many a diabetic has stayed alive by stealing the bread denied him by his doctor.

•Beef broth is that part of the cow which she could not get rid of before she died.

•Gastro-enterostomy; the favorite indoor sport of surgeons.

•A good surgeon is a good medical man who can cut.

•Wait for the public to make you a specialist-don't anoint yourself.

•Socrates was killed by a committee.

•God's interest in the human race is nowhere better evinced than in obstetrics.

•Think any way you please, but know why.

•The philosophy which is your own is the only true religion.

•What we need is a new lot of grade teachers and Sunday school superintendents who can get over once more, the honoring of the fathers, the saving grace of work, and the solid virtue of ambition.

•Change the tenth commandment from thou shalt not to thou shalt, and unemployment would end.

•Sure you can psychoanalyze, but, why bother to sort garbage?

•If you are physically sick, you can elicit the interest of a battery of physicians; but if you are mentally sick, you are lucky if the janitor comes around.

•There is only one reason why men become addicted to drugs; they are weak men. Only strong men are cured, and they cure themselves.

•The first time I see you laugh at an insane man's doings I shall mark you down as a lesser physician, for you don't understand the human drama.

•Idiopathic epilepsy is idiopathic ignorance on the part of the doctor.

•Prize fighters can sometimes read and write when they start-but they can't, when they finish.

•Men do not develop pulmonary edema and die; they develop it because they are dying.

• Let your entrance into the sick room decrease, not increase the irritability of your patient.

•Facts are not science-as the dictionary is not literature.

•Essential hypertension is essential ignorance.

•Here's good advice for practice: Go into partnership with nature; she does more than half the work and asks none of the fee.

•Nowadays the history of the patient often weighs more than the man.

•When I tell you to lead the inner life, I am trying to express these words of the poet: *If I had but one loaf of bread I would sell half To buy white hyacinths To feed my soul.*

-Dwalia South, Editor

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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XII

Selection and Preparation:
Nancy T. Kubiak, M.D.
Edward F. Daly, III, M.D.

Joe C. Files, M.D., *Editor*

Differential Diagnosis: John B. O'Connell, M.D.

Radiological Diagnosis: Michael Doherty, M.D.
H. Chris Waterer, M.D.

Pathological Diagnosis:
Charulochana Subramony, M.D.

CASE PRESENTATION

This is a 37 year old black female with a history of pulmonary blastomycosis seven years ago that was treated with itraconazole for six months. At that time, she presented with acute shortness of breath and her chest x-ray showed diffuse infiltrates. Sputum grew blastomyces, and after appropriate treatment was begun, she showed clinical improvement. Follow up chest x-rays continued to show extensive bilateral fibrotic changes, but the patient remained asymptomatic. The patient did well until three months prior to this admission, when she began to have progressive shortness of breath. Two days prior to admission, her dyspnea became so severe that she "could not walk two steps without stopping to catch her breath". She also reported a ten pound weight loss over the last three months with associated night sweats. She also noted a two week history of PND and orthopnea. She works in a nursing home and recently had a PPD placed which was reportedly negative. She denied joint pains, rash, diarrhea, fever, headache, cough, hemoptysis, or any other complaints.

Her past medical history was negative except as described above. Past surgical history was negative. Her family history was significant for her mother receiving treatment for TB in 1982. Her social history was negative and she was on no medications.

On admission, her physical exam revealed a temperature of 98.6°, her pulse was 110 with a respiratory rate of 22, and her blood pressure was 156/110 with no palpable paradox. Generally, she was a well developed, well nourished, black female in moderate respiratory distress who appeared chronically ill. HEENT: TMs and oropharynx were unremarkable. Her pupils were equally round and reactive to light and accommodation. Her extraocular movements were intact. No other lesions were noted. Neck: no jugular venous distension, no palpable nodes, and no thyroid nodules. CV: tachycardic with regular rhythm, no murmurs, gallops or rubs.

Slightly distant heart sounds were noted. Lungs: bilateral rales in bases and no dullness or egophony. Abdomen: normoactive bowel sounds, soft and nontender, and no hepatosplenomegaly. GU: unremarkable. Extremities: no cyanosis, clubbing, or edema. Neurological exam: completely intact.

Her admission laboratory revealed a white count of 5,400 mm-3 with 70% segs, 15% lymphs, and 12% monos. Her hemoglobin and hematocrit were 14% and 44% respectively. Her platelet count was 285,000 mm-3. She had a serum sodium of 138mEq/L, potassium of 4.2mEq/L, chloride of 101mEq/L, bicarbonate of 28mEq/L, BUN of 12mg%, creatinine of 0.8mg%, and fasting glucose of 112mg%. Her calcium was 9.1%, phosphate was 6.9mg%, albumin was 3.7g%, alkaline phosphatase was 26%, ALT was 69, AST was 37, LDH was 536, and CK was 56. On admission she was receiving oxygen at 2 liters by nasal cannula and her ABGs showed a pO2 of 86mmHg, a pCO2 of 63mmHg, and a pH of 7.331.

Admission EKG showed sinus tachycardia, low voltage QRS, and nonspecific ST/T abnormalities. Chest x-ray on admission showed an enlarged cardiac silhouette, slight hilar prominence, bilateral interstitial infiltrates, and a small right pleural effusion. Decubitus films obtained show no layering of fluid.

The patient was admitted to the General Medicine house service. Initial evaluation included a negative ANA, RF, and HIV. Her ACE level was 29 (normal = 8-52), serum fungal immunodiffusions for Histoplasma, blastomyces, and Coccidioides were all negative. Sputum x 3 were negative for AFB and cytology. Blood cultures were negative.

An echocardiogram showed a very large pericardial effusion with normal left ventricular systolic function. Right atrial and ventricular enlargement were also noted, and there were no valvular abnormalities. Cardiology was consulted and the patient underwent a right heart catheterization with a diagnostic and therapeutic pericardiocentesis of 1.5 liters of yellow hazy fluid. Results showed 1,496 white cells with 26% lymphs, 16% macrophages, and 58% mesothelial cells. Gram stain,

AFB, and fungal studies were all negative. Cytopathological evaluation was negative for malignancy. Hemodynamic data obtained by right heart catheterization before the pericardiocentesis showed pulmonary artery pressure of 95/50mmHg, right ventricular pressure of 90/15mmHg, right atrial pressure of 17mmHz, and a pulmonary capillary wedge of 20mmHg. Post procedure, her pulmonary artery pressure fell to 70/30mmHg, her right ventricular pressure fell to 70/8mmHg, right atrial pressure was 10mmHz, and wedge rose to 35mmHz.

Pulmonary Medicine was consulted. Pulmonary function tests obtained showed FEV1 of 0.9 liters and FVC of 1.1 liters. A chest CT was obtained and showed extensive parenchymal changes bilaterally with relative sparing of the upper lobes. Bronchoscopy was contraindicated due to the poor pulmonary function and pulmonary hypertension.

Dr. O'Connell: In summary, this is a young black woman who had pulmonary blastomycosis diagnosed by a positive sputum culture after she presented with diffuse interstitial infiltrates on her chest x-ray. She was treated for six months with itraconazole and showed clinical improvement. She presented seven years later with a three month history of progressive shortness of breath, ten pound weight loss, and night sweats. She recently had a negative PPD. She works in a nursing home and her mother had been treated for TB in 1982. Her physical examination was not particularly revealing. She had normal chemistries and hemogram except for an LDH that was elevated. She was retaining CO2 and on 27% FIO2 had an A-a gradient of 28mmHg, which was elevated. She had low voltage on her electrocardiogram. Her evaluation consisted of an autoimmune workup, an HIV, ACE level, cytology for malignancy, and immunodiffusions all of which were negative or normal. Her echocardiogram will be shown. She had marked pulmonary hypertension and evidence of left ventricular dysfunction (probably diastolic) with elevation of the pulmonary capillary wedge pressure. She had pulmonary function tests that showed restriction. Dr. Doherty: This is a chest x-ray from when the patient was originally diagnosed with blastomycosis. The patient has a normal size cardiac silhouette and diffuse bilateral interstitial infiltrates. The chest x-ray on admission shows a marked enlargement of the cardiac silhouette. There is a water-bottle shape and the bilateral interstitial infiltrates are present.

There is a small right pleural effusion. In the slices from the CT obtained after admission, there is fluid around the heart and in the pericardium representing pericardial effusion that is causing the large cardiac silhouette. There is also a small right pleural effusion, and even a small left pleural effusion. On the CT, there is diffuse bilateral parenchymal lung disease. There is some alveolar disease. There is also some linear thickening representing some interstitial disease. A high res CT chest was obtained at the same time. There is some interlobular thickening representing some interstitial lung disease. There is a general ground glass appearance that represents both interstitial and alveolar lung disease. The chest x-ray that was done after the pericardiocentesis shows a decrease in the size of cardiac silhouette and the interstitial infiltrates that are still present.

Dr. Waterer: The echo that was done shows the distance between the left ventricular wall and the pericardium to be 8-10cm, which indicates a large effusion. The heart is water bottled shaped. The left ventricular function is normal. The size of the ventricle is normal. The right ventricle is enlarged. There is biventricular hypertrophy. The heart swings to and fro, and that is the explanation of electrical altervans seen on an EKG. This is a huge pericardial effusion. There is no evidence of tamponade by the echocardiogram.

Dr. O'Connell: There are two salient features of this case that must be explained. This patient has a seven year history of interstitial lung disease and a large pericardial effusion. At the top of our list in the differential diagnosis of interstitial lung disease (Table I) is infection and several types of infection should be considered.

Table 1
Classification of Interstitial Lung Disease

Infections
Virus
Bacterial (pyogenic, mycobacteria)
Fungal
Parasitic (schistosomiasis)
Protozoal (Pneumocystis)
Drugs
Cardiac disease
Inhalation injury (pneumoconiosis, allergic alveolitis, aspirator, fumes & gases, O2 toxicity)
Neoplasms
Radiation
Idiopathic
Sarcoid
Autoimmune disease
IPF: Idiopathic pulmonary fibrosis
Histiocytosis X
Pulmonary hemorrhagic syndromes

Table II
Classification of Pericardial Effusion

Infectious
Viral, pyogenic, mycobacterial, mycotic, other

Non-Infectious

Acute MI	Aortic aneurysm
Uremia	Postirradiation
Neoplasia	Chronic anemia
Myoedema	Familial
Cholesterol	Trauma
Sarcoidosis	Idiopathic

Autoimmune disease

Hypersensitivity

Information relevant to mycobacteria (past TB exposures) has been provided, as well as information on the initial onset of interstitial disease attributed to blastomycosis. The differential diagnoses further include drug toxicity, cardiac disease, inhalation injury, neoplasm, radiation, and an idiopathic process. Pericardial effusions are classified on Table II. The first step is to consider diseases appearing on both lists; therefore, eliminating conditions that probably are not relevant. If there were two completely different processes operational, this discussion would be very difficult and a bit unfair. Consequently, I am going to make the assumption that both of the presenting signs arise from the same pathophysiologic process.

The common diagnoses include infection and several noninfectious disorders, and hypersensitivity. Infections that may lead to pericardial effusion and chronic interstitial lung disease must be carefully considered, and tuberculosis warrants further discussion.

Blastomycosis must be considered. Autoimmune disease is also high on the list and must have been considered by her physicians because a diagnostic evaluation was pursued. Malignancy is less likely because of the seven year duration. Finally, sarcoidosis must be considered. Pulmonary blastomycosis presents as an acute or chronic disease. Much of the recent work on this fungus was completed by an NIH collaboration, the Mycosis Study Group. Dr. Stanley Chapman, Director of our Division of Infectious Diseases, is an active contributor in this group. When blastomycosis presents as an acute process (generally < 3 weeks duration), it may be a totally asymptomatic disease or it may present as an influenza-like syndrome with fever, chills, cough, and myalgias, or as a pleuritic syndrome. The chronic form of the disease results either from spread of acute pulmonary disease or endogenous reactivation. The chest x-ray in blastomycosis may show alveolar infiltrates and mass lesions, a miliary pattern, or a reticulonodular pattern predominating in the upper lobes. Mediastinal lymphadenopathy and large pleural effusions are unusual. The extrapulmonary manifestations of blastomycosis include the skin as the most common extrapulmonary site, followed by bone and joints, the GU tract, reticuloendothelial system, subcutaneous tissue, the upper airway mucosa, and thyroid. Myocardial or pericardial involvement would probably be reportable and when present results as an extension from a contiguous source with abscess formation and rupture into the pericardial space.

The treatment of pulmonary blastomycosis is usually rewarded with resolution in the non-immunocompromised host. Itraconazole 400mg/day for six months, which she received, will cure more than 95% of these patients with rapid resolution of symptoms and radiographic disease. This disease may spontaneously resolve without any treatment at all. Her supporting the diagnosis pulmonary blastomycosis is a bit unusual in the fact that despite her good clinical response, her chest x-ray never resolved and in fact there was progression. Although it is hard to refute the positive culture for blastomycosis from the sputum, perhaps there was another process that was contributing to the interstitial lung disease even seven years ago. Therefore, I do not believe this is pure blastomycosis for the following reasons: a poor radiographic response to itraconazole, a negative immunodiffusion for blastomyces (positive in over 80% when blastomycosis is active), the wrong patient profile (blastomycosis is more common in males), the upper lobe is not typically spared, pericardial involvement is exceedingly unusual, and finally, the pericardial fluid was cultured and was negative for the fungus.

Tuberculosis must be considered. Hers would have been an extremely long course for untreated active pulmonary tuberculosis, particularly with those strains seen in Mississippi today. She had a negative PPD recently. Her upper lobes were spared on the CT scan and the AFB on the pericardial effusion was negative. The pericardial effusion caused by TB generally results from epicardial involvement or spread from a contiguous source. Her fluid culture was negative.

There is not enough information in the protocol to seriously consider autoimmune disease. There are no suggestive symptoms and the ANA and rheumatoid factor were negative.

By eliminating the other diagnostic categories, strong consideration should be given to sarcoidosis. Sarcoidosis is a disease that is common in African-American females. Demographically, the prevalence is 40 cases per 100,000 in the African American population and there is a 2:1 preference for females. The most common age at diagno-

sis ranges from 20 to 40 years. She fits that profile very nicely. Sarcoid lung disease may occur without the more typical mediastinal lymphadenopathy. In fact, class III sarcoid consists of parenchymal lung disease alone. Pericardial effusion in sarcoidosis is mentioned only casually in the major textbooks, but not with any detail. A recent paper by Angomachalelis, et al, reported 81 patients with biopsy proven systemic sarcoidosis and found 21% with no other evidence of heart disease had a pericardial effusion on echocardiography. Concomitant myocardial involvement was suggested in 13 of the 14. The presence of pericardial effusion did not correlate with symptoms. Fifteen of seventeen patients were asymptomatic for the effusion. In our patient with a very high pulmonary artery pressure and a large A-a gradient, it is hard for me to relate her symptoms specifically to the pericardial effusion although there may be some contribution by further pulmonary comprise due to compression of adjacent lung by the fluid.

The importance of the ACE level always seems to be discussed in our sign-in conferences. Angiotensin converting enzyme levels are increased in 50-80% of patients with sarcoidosis, but interpretation of results must only be viewed in comparison to a baseline value; i.e. 29 units may in fact be an abnormal value for her. Serial changes may reflect the disease course; therefore a single ACE level, if normal, provides no help in the assessment. Most experts feel that utilization of the ACE level is also unhelpful in following patients with sarcoidosis.

I believe this woman probably has sarcoidosis. Whether or not she has underlying pulmonary blastomycosis and superimposed sarcoidosis can not be ascertained. If she did, it does not appear to be active currently.

To establish the diagnosis, the first step is pericardiocentesis and fluid analysis which we are given as non-non-diagnostic. Tissue is necessary to establish the diagnosis of sarcoidosis. Bronchoscopy and a transbronchial biopsy is probably out of the question because of her pulmonary hypertension and her extensive lung disease. We are given the fact that she does not have peripheral lymphadenopathy and hence no easy access. Which procedure is most apt to result in a diagnosis with least risk? I assume she has pericardial involvement. Determination of likely epicardial or myocardial involvement is appropriate. Several noninvasive techniques to detect myocardial sarcoidosis have been proposed. The inflammation-avid radioisotope, gallium 67, may be taken up by active sarcoid lesions. However, as her chest x-ray suggests, if the Ga G7 scan is positive she would have extensive pulmonary uptake, making cardiac interpretation next to impossible. Thallium perfusion imaging has also been proposed as a means of diagnosing sarcoid heart disease. Another option that is readily available at UMMC is endomyocardial biopsy. The option that is most invasive requiring an open surgical procedure is myoepicardial or pericardial biopsy.

The first key question regarding likelihood of non-surgical intervention is do we believe the heart is involved. Between 20 and 60% of patients with sarcoidosis have myocardial involvement, which in most instances is asymptomatic. Consequently, there is probably one third chance that this woman has cardiac involvement. The next key question is what is the likelihood a diagnosis of sarcoid heart disease could be established by endomyocardial biopsy, which is not directed toward an area of probable involvement. Although a diffuse lymphocytic infiltrate may occur in patients with sarcoid heart disease, non-caseating granulomata remain the most common histologic manifestation. The granulomata tend to be subepicardial more often than subendocardial and tend to be focal. If the granulomata involve the septum, heart block may result. If the papillary muscles are involved, A-V valvular regurgitation may result. Even though multiple areas of the heart may be involved, other areas are generally normal. There are several reports on the effectiveness of endomyocardial biopsy in establishing the diagnosis of cardiac sarcoidosis. Dr. Sekiguchi in Japan mimicked endomyocardial biopsy 15 years ago in autopsied hearts that had sarcoid involvement, and was able to establish the diagnosis in 63% by blind biopsy of the right and 47% of the left ventricle. In a more recent paper, Ratner, et al, made the diagnosis by biopsy in 50% of patients who had known sarcoid in other organs and had presented with presumed cardiac involvement. The diagnosis will be made about half the time, but multiple specimens (> 6) must be analyzed. Endomyocardial biopsy will never be able to rule out cardiac sarcoidosis, but it will be able to rule it in. However, the low complication rate of endomyocardial biopsy make this an attractive procedure. Hemopericardium, as a result of cardiac perforation, occurs in < 0.5% with experienced ands. Emboli are associated with left ventricular biopsy not right ventricular biopsy.

In this patient, there are two options for diagnosis. Tissue must be obtained by either endomyocardial biopsy with minimal discomfort and low morbidity but only a 50% chance of making the diagnosis, or a pericardial window with open biopsy of the pericardium in order to establish the diagnosis.

Dr. Daly: The patient was taken to the OR and had a pericardial window done, and they also did a biopsy of her left peritracheal node.

Dr. Subramony: The lymph node shows multiple

non-caseating granulomas are composed of epithelioid histiocytes. Ziehl-Neelson stain for acid fast organisms and Gomori's methenamine silver stain for fungal organisms are negative. The pericardial biopsy shows thickened fibrotic pericardium with mild nonspecific inflammation and mesothelial proliferation. No granulomas are noted in the pericardial biopsy.

The diagnosis is non-caseating granulomas consistent with sarcoidosis.

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***Dr. Files** is Professor of Medicine and Associate Chair man for Clinical Affairs, Department of Medi cine. **Dr. O'Connell** is Professor and Chairman of the Department of Medicine; **Dr. Doherty** is a resident in Department of Radiology; **Dr. Waterer** is Assistant Professor of Medicine; and **Dr. Subramony** is Associate Professor in the Department of Pathology. All at UMMC.*

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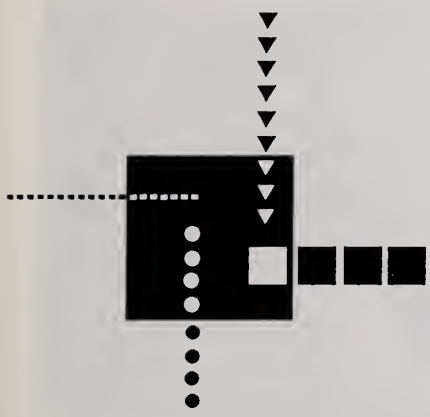
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The MSMA Alliance held its Emeritus Tea at the home of ***Mrs. Carl G. Evers****. Shown are some of the ladies present. Top left:* ***Mrs. W. Moncure Dabney*** *(left),* ***Mrs. Henry H. Webb*** *(right); Top right:* ***Mrs. Gary H. Nowell, Mrs. Daniel Draughn, Mrs. Evers;*** *Middle right on left: Mrs. Clarence Webb; Bottom left:* ***Mrs. Max L. Pharr, Dr. Nina B. Moffitt;*** *Bottom right:* ***Mrs. John B. O'Connell, Mrs. Daniel W. Jones, Mrs. James R. Cavett.***





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Sandra M. Grissom, Fifth Grade Teacher

cc: Cathy Gersh, MSMAA

PS: Mrs. Gersh, please extend our appreciation to the MSMA and MSMAA for providing this worthwhile opportunity to our young people. Mr. Thompson was wonderful!!

Health Choice '96, March 18 - 22, was again a huge success. Over 6,000 children, 5th - 12th grades, heard JeVon Thompson's message on personal empowerment and self esteem. The program was well received across the state with plenty of invitations to return next year! The Health Promotions committee would like to thank the alliances in Vicksburg, Hattiesburg, Laurel, Singing River, Gulfport, and Jackson for hosting Health Choice '96 and making it all possible. The MSMAA would also like to thank the Mississippi State Medical Association for providing the funding for such a worthwhile program !

Cathy Gersh
Health Promotions





BIGLER, STEVEN A., Jackson. Born Salt Lake City, UT, April 3, 1959; MD University of Utah School of Medicine, Salt Lake City, UT, 1988; pathology residency, University of Washington, Seattle, WA, 1986-89; elected by Central Medical Society.

BOONE, SCOTT A., Southaven. Born Meridian, MS, January 4, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; internal medicine residency, Baptist Memorial Hospital, Memphis, TN, 1990-94; elected by Desoto County Medical Society.

BROOME, CHARLENE B., Greenville. Born Jackson, MS, July 1, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1989; pediatric residency, University of Tennessee, Memphis, TN 1989-90, and University of Kentucky, Lexington, KY, 1990-92; allergy & immunology fellowship, Duke University Medical Center, Durham, NC, 1993-95; elected by Delta Medical Society.

BROOME, DAVID V., Greenville. Born Hammond, LA, March 28, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1989; interned one year, Baptist Memorial Hospital, Memphis, TN, 1989-90; anesthesiology residency, University of Kentucky Medical Center, Lexington, KY, 1990-93; elected by Delta Medical Society.

ECKMAN, MARK A., Jackson. Born Rutland, VT, October 15, 1963; DO University of Osteopathic Medicine and Health Sciences, Des Moines, IA, 1991; family medicine residency, University Medical Center, Jackson, MS, 1992-94; elected by Central Medical Society.

FULCHER, TODD L., Jackson. Born September 3, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1990; family medicine residency, University Medical Center, Jackson, MS, 1989-92; elected by Central Medical Society.

MANNING, J MICHAEL, Jackson. Born Drew, MS, August 7, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1991; interned one year, Methodist Hospital, Memphis, TN; anesthesiology residency, Bowman-Gray Medical Center, Winston Salem, NC, 1992-95; elected by Central Medical Society.

MELANCON, KEITH P., Hattiesburg. Born Ames, IA, April 7, 1964; MD Louisiana State University School of Medicine, New Orleans, LA., 1991; orthopaedic residency, University of Mississippi Medical Center, Jackson, MS, 1991-96; elected by South MS Medical Society.

MELILLO, ANTHONY S., Jackson. Born New Jersey, January 18, 1960; MD Medical College of Wisconsin, Milwaukee, WI, 1986; orthopaedic surgery residency, Naval Hospital, San Diego, CA, 1989-93 and one year Massachusetts General Hospital, Boston, MA; elected by Central Medical Society.

RAFIQUE, SYED S., Greenwood. Born Pakistan, March 13, 1959; MD Puntab University Pakistan, 1984; internal medicine residency, State University of New York Health Sciences Center, Brooklyn, NY, 1989-92; hematology/oncology residency, same, 1992-95; elected by Delta Medical Society.

SCOTT, PHILIP L., Jackson. Born Oklahoma City, OK, March 21, 1958; DO Oklahoma State University of Osteopathic Medicine, Oklahoma, OK, 1986; psychiatry, child & adolescent and adult residency, University of Arizona Medical Center, Tucson, AZ, 1987-91; elected by Central Medical Society.

REINSTATEMENT:
Milam S. Cotten, Hattiesburg
Al Flannery, Iuka
Gail C. Megason, Jackson
Randall L. Nance, Philadelphia
Lynn E. Leatherwood, Gulfport
Rebecca J. Waterer, Jackson

DEATHS:

Ferguson, J. Scott, Starkville. Born Kosciusko, MS, April 17, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1989; internal medicine residency, Memorial Medical Center, Savannah, GA,; died March 3, 1996 age 32.

Lauderdale, J. A., Jr., Meridian. Born in New Hebron, MS, July 31, 1914; MD Tulane University School of Medicine, New Orleans, LA, 1941; interned one year Baroness Erlanger Hospital, Chattanooga, TN; died March 17, 1996, age 81.

Russell, Jerry Ted, Vicksburg.

Born Carthage, MS, December 1, 1938; MD University of Mississippi School of Medicine, Jackson, MS, 1967; interned one year Parkland Memorial Hospital, Dallas, TX; radiology residency, Universtiy Medical Center, Jackson, MS, 1/1/67 - 12/31/72; died February 18, 1996, age 57.

Thornton, William L., Meridian. Born San Antonio, TX, October 21, 1923; MD University of Pennsylania School of Medicine, Philadelphia, PA, 1947; interned one year Parkland Hospital, Dallas, TX; surgical residency, same, 1948-52; died March 31, 1996 age 72.

Physicians' Recognition Award



Two MSMA members were named recipients of the AMA Physicians Recognition Award in March 1996. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Singing River Medical Society
Donald Edward Doyle, MD

South Mississippi Medical Society
Howell, George Eli, MD

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Personals



Field Memorial Community Hospital Lectureship-Dr. C. Rollins Hanlon, (right above), former president of the American College of Surgeons and Emeritus Professor of Surgery, St. Louis University and Northwestern University, Chicago was the guest speaker for the 18th annual lectureship sponsored by the Wilk-Amite Medical Society which was held at the Centreville Academy on Thursday, March 28. Dr. Hanlon Dr. Hanlon spoke on the life and accomplishments of Florence Nightingale, the founder of modern nursing. Pictured above with Dr. Hanlon is **Dr. R. J. Field, Jr., Field Memorial Community Hospital chief of surgery.** Despite the controversy over Nightingale, who was known to be obsessed with her impending death and who became reclusive in later life, there is no question about her tremendous impact on military nursing resulting from her experiences during the Crimean War.

William M. Swartz, M.D., F.A.C.S. Clinical Associate Professor of Surgery Division of Plastic Surgery University of Pittsburgh School of Medicine will be the speaker for the **J. T. Davis Visiting Professor of Hand Surgery,** May 20-22. Dr. Swartz will present "The Diagnosis and Management of Vascular Problems in the Upper Extremity," "Problem Cases by Hand Surgeons in the State," "Decision Making in Upper Extremity Soft Tissue Coverage," "Lower Extremity Ulcers of Diabetic and Vascular Origin." A dinner will take place at Dr. and Mrs. Michael Jabaley's home Tuesday evening, May 21. For registration information contact Joyce Addy, Division of Plastic Surgery, University of Mississippi Medical Center, (601) 984-5084.

William E. Roberts, M.D., associate professor of ob-gyn, University of Mississippi Medical Center, was singled out for recognition at the annual meeting of the Association of Professors of Gynecology and Obstetrics and the Council on Resident Education in Obstetrics and Gynecology in Albuquerque, New Mexico. Roberts' poster presentation, "Does the Electronic Residency Application Service (ERAS) Affect Prospective Resident Demographics?" won best overall poster at the meeting. His presentation in electronic submission of data by resident candidates was the first study in the United States to address this issue.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.



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Managed Care Contracts...Protecting Your Right

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

❧ Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.

❧ Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.

❧ Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction premium for the hospital, bu there is much more that the physician should consider th just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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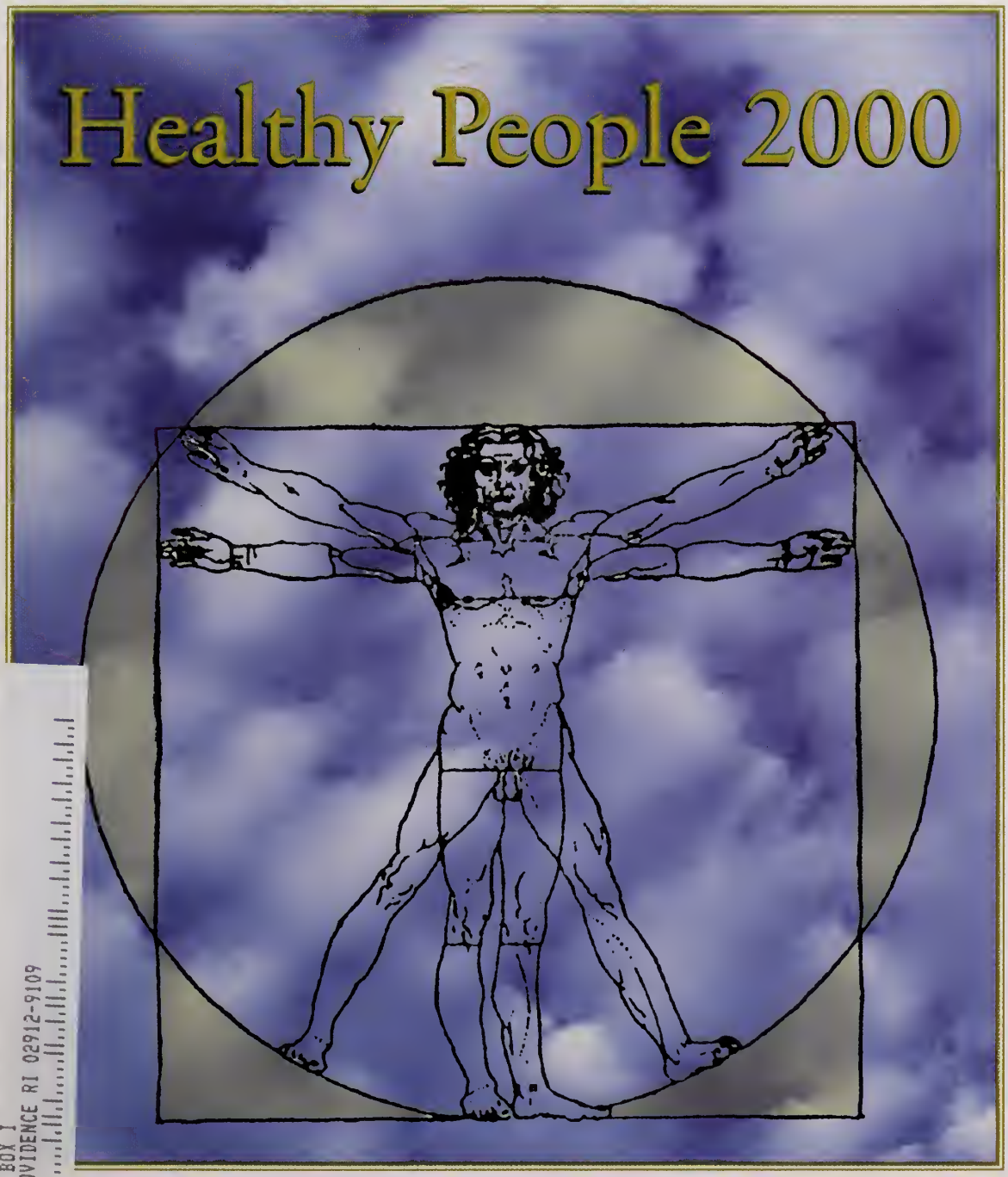
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Healthy People 2000 Goal 1.12: Primary Care Physicians and Exercise Counseling

Gary Royals, B.S.N., R.N.
Linda F. Chitwood, Ph.D.
Leigh Ann Davis, M.S.
Judith Cole, Ed.D.

Abstract

The Healthy People 2000 Goal 1.12 was designed to increase to 50% the number of primary care physicians who regularly counsel their patients concerning the appropriate frequency, duration, type and intensity of exercise. To assess the overall progress in relation to this goal, a survey of 212 physicians was conducted in an eight-county region of northern Mississippi. Fifty-nine physicians completed and returned the survey. The findings indicate that 90% of the physicians perceive exercise to be important and that they are discussing exercise with approximately 50% of their patients aged 40 and older. However, the average length of the counseling segment is two minutes or less. It is therefore probable that the appropriate frequency, duration, type and intensity of exercise may not be adequately discussed during physician-based exercise counseling.

Key Words: **physical activity, exercise counseling, patient education**

In 1990 the U.S. Department of Health and Human Services, the Public Health Service, and a national consortium of nearly 300 agencies developed the "Objectives for National Health Promotion and Disease Prevention." These goals/objectives were designed for physicians and other health care professionals to help their patients with: 1) the prevention of premature disease and disability, 2) a reduction in individual health care costs and 3) the achievement of a healthier and more productive life.[1] It was anticipated when the goals were developed that their achievement would be possible by the year 2000, thus the Healthy People 2000 project was initiated.

In recognition of the health-related benefits of physical activity, Healthy People 2000 goals included recommendations for physical activity for all age groups. Healthy People baseline data suggested that only 10% of the adult population engaged in vigorous physical activity and that almost one-half of the population aged 65 and older did not engage in any type of physical activity.[1] Given these statistics and the percentage of adults (85%) that believe a doctor's recommendation would motivate them to exercise regularly, the Healthy People 2000 Goal 1.12 was developed to encourage physicians to become more active in counseling their patients concerning regular physical activity. Specifically, Goal 1.12 is to "increase to at least 50% the proportion of primary care

providers who routinely assess and counsel their patients reguarding the frequency, duration, type and intensity of each patient's physical activity practices."[1]

Healthy People 2000 baseline data (1988) indicated that physicians provided exercise counseling for about 30% of their sedentary patients.[1] More recent reports have shown physician counseling to be as high as 91%[2] and as low as 25%[3]. Although data concerning physician-based exercise counseling for the state of Mississippi have not been published, the importance of these counseling activities should not be overlooked since 68% of Mississippi's citizens currently lead sedentary lives[4]. January 1996 marks the final four-year period in which Goal 1.12 can be achieved prior to the year 2000. The purpose of the current project was to determine the status of physician-based exercise counseling in north Mississippi. Specific objectives were to: 1) ascertain the physicians' perceived importance of including exercise in their average patient's plan of care, 2) assess the percentage of patients who receive exercise counseling for chronic medical conditions as compared to those who are essentially healthy, 3) determine the amount of time physicians spend with their patients in exercise counseling, and 4) determine whether physician based exercise counseling is physician or patient initiated.

Methods

A survey was developed and mailed to 212 physicians. The physicians were selected for inclusion in the survey if they provided direct medical services to patients over 40 years of age in an eight county region of northern Mississippi. The counties were: Lafayette, Union, Pontotoc, Lee, Itawamba, Monroe, Chickasaw, and Calhoun. The questionnaire was mailed to the physicians with a cover letter which defined the purpose of the study. The physicians were asked to complete and return the questionnaire by mail in a pre-stamped and pre-addressed envelope. In an effort to improve the response rate, physicians were not required to identify themselves.

Results

Fifty-nine of the 212 physicians responded to the survey, resulting in a return rate of 28%. Only two of the original questionnaires were returned by the postal service as "non-deliverable" and no second mailing attempt was made.

The first objective of the survey was to measure the physicians' perceived importance of exercise in the average patient's plan of care. The results clearly show that the physicians do recognize the role of exercise in the prevention and management of disease. Of the 59 responding physicians, 90% felt that it was either 'always' or 'usually' important to include exercise in the patient's plan of care. Only 2% indicated that exercise should 'never' be a part of the plan of care, while 5% indicated that it should 'rarely' be included (Figure 1).

The frequency with which physicians provide exercise counseling was also assessed. Information regarding the provision of exercise counseling (never, rarely, usually, always) to patients who are essentially healthy, hypertensive, arthritic, diabetic, and obese was sought. These results are presented in Figure 2. Fifty-eight percent of the physicians regularly (usually or always) counsel essentially healthy patients concerning exercise. Patients most frequently counseled are those who are obese (80%) while those who are hypertensive, arthritic and diabetic receive counseling approximately 50% of the time.

The physicians were asked to indicate how much time per patient visit is spent discussing exercise. The results indicate that the average physician/patient exercise discussion is typically two minutes or less in length (Figure 3). The final question was designed to determine whether exercise counseling was initiated by the physician or at the request of the patient. As indicated in Figure 4, the physician is largely responsible for the initiation of exercise-related discussions. Of the responding physicians, 75% indicated that less than one-quarter of their patients aged 40 and over initiated the discussion regarding exercise.

Discussion

The purpose of this study was to describe the exercise counseling habits of primary care physicians in north Mississippi. The implications of the results are limited by the low response rate of the 212 physicians. However, some encouraging news and some points of potential progress are provided. The results show that primary care physicians in north Mississippi recognize the importance of exercise in the average patient's plan of care, that they believe it important enough to initiate exercise counseling, and that they are, in general, counseling at least 50% of their patients aged 40 years and over. These are all positive points for the citizens of Mississippi and important steps toward achieving Healthy People 2000 Goal 1.12.

Figure 1: Physicians' perceived importance of exercise

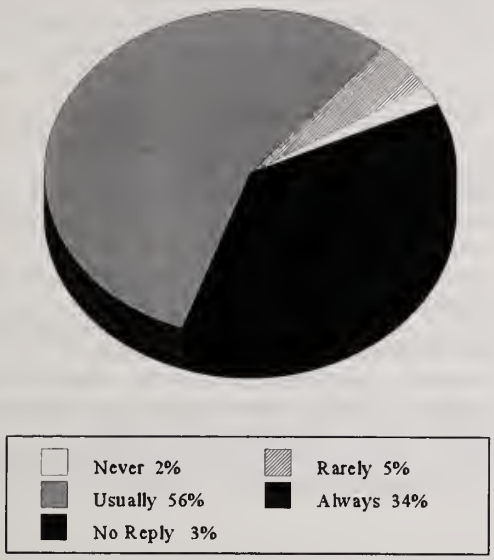


Figure 2: Frequency of counseling for patients over 40

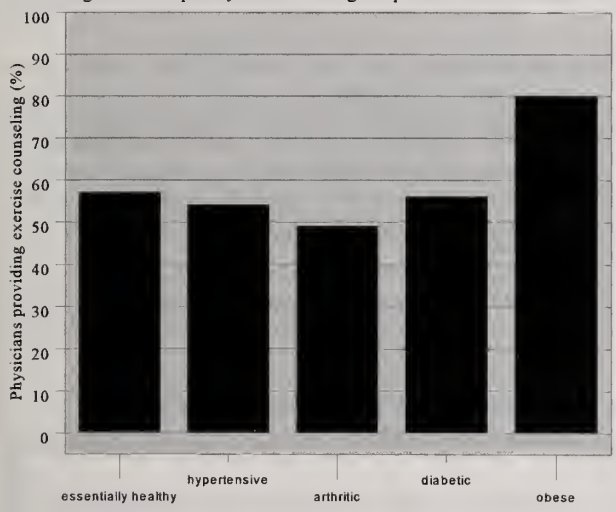


Figure 3: Duration of physician-based exercise counseling

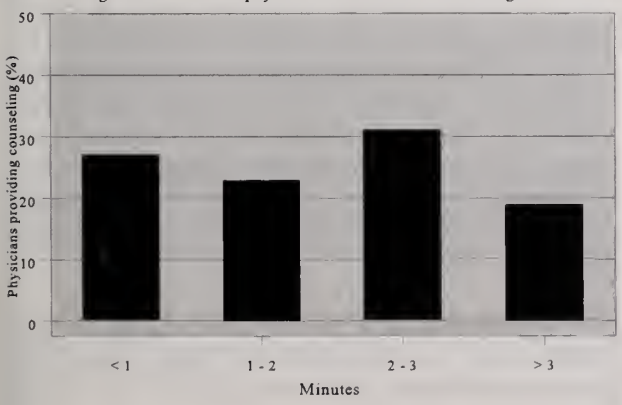
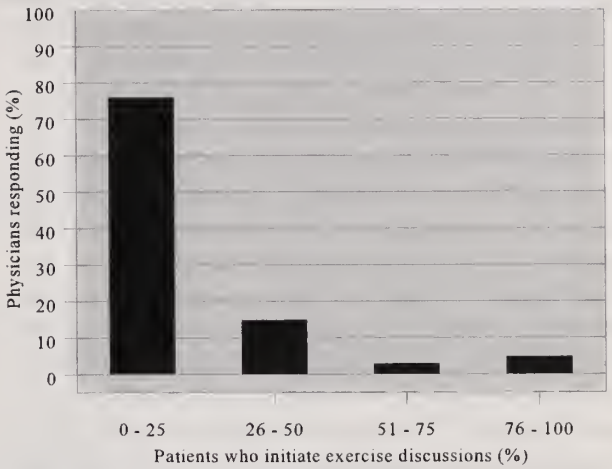


Figure 4: Physician vs patient initiated exercise counseling



Mississippi physicians' perception of exercise counseling is not different than that reported by other physicians. In the current survey, 90% indicated that exercise counseling is important. Other studies[3,5-6] have also reported that 85-90% of physicians believe exercise to be an important part of the patient's plan of care. No doubt this belief is influenced by the volume of epidemiological data indicating that regular physical activity reduces the risk of developing a number of lifestyle-related diseases, including hypertension, coronary heart disease, obesity, arthritis, and diabetes. This study was unique in that it sought to identify the initiator of exercise counseling—the patient or the physician, thereby providing some indication of the patient's interest in exercise. In general, less that one-fourth of the exercise discussions were initiated by the patients. If interpreted as a lack of interest on the part of the patients, it may explain, in part, why so many Mississippians continue to lead sedentary lives.

Much of the available research has focused on the frequency with which physicians provide exercise counseling. In the present study, the frequency of exercise counseling varied from 49% for arthritic patients to 80% for the obese. Approximately 50% of the essentially healthy patients over the age of 40 were counseled on a regular basis. The implications of these data are threefold. First, the physicians are consistently approaching the 50% recommendation stated in Healthy People 2000 Goal 1.12. Second, the frequency of physician-based exercise counseling is influenced by health status of the patient. Perhaps the clear association between obesity and inactivity is responsible for the high percentage of obese patients who are counseled concerning regular physical activity. Third, those who remain essentially healthy beyond the age of 40 still require consistent prodding to develop regular exercise habits.

Possibly the most important point of future progress relates to the amount of time a physician spends counseling patients concerning exercise. Most physicians spend two minutes or less counseling each patient about exercise. The Healthy People 2000 goal calls for physician-based counseling concerning the frequency, duration, type and intensity of each patient's physical activity practices. Although Mississippi physicians appear to be meeting the initial portion of Goal 1.12 by counseling 50% of their patients, it is doubtful that the specifics (frequency, duration, type and intensity) of exercise counseling are being achieved in two minutes or less. Additionally, the 1988 Healthy People 2000 baseline data showed that the average length of exercise counseling was already two minutes[1]. Recently, Lewis[7] reported that 48.5% of physicians indicated that they spend longer than three minutes in their average exercise counseling session. In the present study, only 15% of the physicians spent at least three minutes per session.

Conclusion

In conclusion, two areas of opportunity for physicians to enhance their effectiveness regarding exercise counseling are suggested. First, physicians could strive to increase the number of patients who receive exercise counseling. Here the goal might be to achieve the 80% rate currently reported for the obese patients. The second opportunity would be to increase the amount of time spent in exercise counseling activities to greater than three minutes thereby providing more time for assessment, prescription, and evaluation of exercise for the average patient. This action would provide the patient with more information during the session, would allow more questions, and would provide better evaluation of individual needs. However, the challenge remains to effectively achieve such a goal when physician workloads and responsibilities are ever increasing.

Supportive health-care professionals, especially exercise physiologists, need to facilitate physician-based exercise counseling by providing the physician with quick and simple methods of exercise prescription for persons aged 40 and over. Additionally, fitness professionals should avail themselves to physicians for patient referral when additional exercise counseling is needed. Cooperative efforts between physicians and fitness professionals could have a dramatic impact on the quality of patient care and consequently increase the number of Mississippians who regularly participate in physically challenging activities. ❑

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NATIONAL HIV TELEPHONE CONSULTATION SERVICE

The National HIV Telephone Consultation Service, "Warmline" (800-933-3413) based at San Francisco General Hospital provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists, and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 am and 5:00 pm PST. A twenty-four hour voice mail system is available at other times.

The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers, and the American Academy of Family Physicians.

Issue At End of Life Is Quality of Care

Providing quality of care at the end of life, not assisted suicide, is the real issue before Americans, Lonnie R. Bristow, MD, president of the American Medical Association told House Judiciary Committee.

Testifying with a dozen other opinion leaders, Dr. Bristow pointed out that physicians' venerable injunction "to give no deadly drug" has been challenged by the recent dramatic advances in medical knowledge and technology. These advances have allowed medicine to prolong life beyond the span that nature would have permitted.

Needed are further efforts "to better educate physicians in the areas of pain management and effective end-of-life care," Dr. Bristow said. "Patients who are understandably apprehensive or afraid of their own mortality need support and comforting, not a prescription to help them avoid the issues of death."

Instead of debating physician-assisted suicide, we should all focus on two areas that require further clarification, according to Dr. Bristow's testimony: Withholding or withdrawing treatment; and the double effect of pain management. Clarifying how these two procedures work in the context of end-of-life care should lead to better understanding about why it is unethical for physicians to cross the line and become active agents in a patient's suicide.

Withdrawing treatment does not cause death, Dr. Bristow said. Rather, it allows "death to proceed naturally, with the underlying disease being the cause of death." A double effect sometimes occurs when "the administration of adequate pain medication has the secondary effect of suppressing the respiration of the patient, thereby hastening death."

Further dialogue -- and perhaps legislation -- is needed to clarify the "double effect," since the current legal environment can have a chilling effect on physicians' ability to control intractable pain for terminally ill patients.

"California and Texas have developed clear legislative guidance that resolves these concerns for most physicians," he said. "The AMA is developing similarly structured model legislation for state medical societies to pursue with their state legislatures and medical licensing boards."

The AMA also is developing a comprehensive patient and physician outreach campaign focusing on quality of care at the end of life. The campaign will be informed by a list of recommendations produced by a special task force and approved by the AMA House of Delegates at its December 1995 meeting.

"The report identified issues involved with care of the dying, including the need to develop a definition of "futility," provision of optimal palliative care, legislation ensuring access to hospice benefits, and the importance of advance care planning as a part of standard medical care," he said.

"The movement for legally sanctioning physician-assisted suicide is a sign of society's failure to address the complex issues raised at the end of life," said Dr. Bristow. "It is not a victory for personal rights. "Our response should be a better informed medical profession and public, working together to-preserve fundamental human values at the end of life."

CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XIII

Selection and Preparation:
Richard D. Guynes, M.D.
Roger L. Huey, M.D.
Michael R. McMullan, M.D.

Joe C. Files, M.D., *Editor*

Differential Diagnosis: David N. Duddleston, M.D.
Radiological Findings: Pollyanna Barlow, M.D.
Pathological Findings: Sue Walker, M.D.

CASE PRESENTATION

A 57- year- old white female was diagnosed with acute myelogenous leukemia, subtype M-1, in February, 1994, and is status-post induction and consolidation chemotherapy with Ara-C, VP-16, Vincristine, and Daunomycin. She returned to the Hematology clinic two weeks after consolidation course #2 feeling well overall, except for noticing some bruising and a small pinpoint rash on her lower extremities. She denied any fever or chills, cough, shortness of breath, chest pain, or other complaints.

Past medical history was positive for hypertension and hiatal hernia. Past surgical history was positive for a right supraclavicular broviac placement. Her only medication was Zantac 150mg po b.i.d. She was not allergic to any medications. She denied alcohol or tobacco use. She did have a family history that was significant for a father with lung cancer.

On physical exam, she had a temperature of 98.8, a pulse of 118, a respiratory rate of 20, and a blood pressure of 144/86. Generally, she was an obese white female in no acute distress. She was alert and oriented x 4. HEENT showed alopecia. Her oropharynx was edentulous with no lesions noted. Neck was supple without adenopathy. No JVD was noted. On chest exam, she had no discharge or erythema at her broviac site. It appeared clear. Cardiovascular showed a regular rhythm with a grade 2/6 holosystolic ejection murmur at the left lower sternal border. No S3 or S4 was noted. Her lungs initially were clear to auscultation bilaterally. No rales or rhonchi were noted. Abdominal exam: She was obese, nontender, nondistended, and had no hepatosplenomegaly. She had active bowel sounds in all quadrants. On her rectal exam, she was heme negative and no masses were noted. On her extremities, she had numerous petechiae on both lower extremities with a 5cm region of ecchymosis on her left upper thigh. Her neurological exam was intact with no focal deficits noted.

On admission, her laboratory was significant for a white count of 13.6 with 16% blasts. Her hemoglobin and hematocrit were 9 and 28. She had 28,000 platelets. PT and PTT were within normal limits. She had a sodium of 140, a potassium of 3.9, a chloride of 101, and a CO_2 of 31. Her BUN and creatinine were within normal limits at 14 and 0.8. Her glucose was 108. Calcium and phosphorus were within normal limits. Her total protein was 6.9, albumin was 3.6, alk phos was 78, GGT was 68, AST was 105, and ALT was 80. Her LDH was 9,354. Her CK level was < 20 and uric acid was 12.4. A urinalysis showed trace protein and 3 white cells; otherwise was normal. Her admission chest x-ray revealed a normal cardiac silhouette, clear lung fields, and a right subclavian catheter in place.

This patient was admitted to the Medicine house staff and underwent a bone marrow aspirate which showed 75% cellularity, predominately blasts, with a positive Sudan stain in 15-20%. She was felt to have a relapse of her AML and was begun on chemotherapy consisting of Ara-C, Daunomycin, and Cyclosporine.

On day two of chemotherapy she spiked a temperature to 102°. Blood and urine cultures were obtained at that time, and she was started on Ampicillin, Fortaz, and Clindamycin. She defervesced on this regimen. The return of those cultures were all negative. By day eight of chemotherapy she became pancytopenic. She required hematological support with numerous packed cell and platelet transfusions. On day ten she developed nausea, anorexia, and diarrhea. Stool for OCP, C. difficile, and white cells were sent, all of which were returned negative. She was started on TPN.

She received a 14 day course of Ampicillin, Fortaz, and Clindamycin, remaining afebrile but neutropenic. On hospital day 15, she became febrile with a temperature of 103.5°. She remained neutropenic at that time with a white count of 300. She was re-cultured and the Ampicillin and Clindamycin were changed to Vancomycin. She remained febrile for two more days and Amphotericin B was started at 35 mg per day. On this regimen, she remained febrile for the following five days at which time she developed acute shortness of breath. Physical exam showed bilateral rales to the mid lung fields, diffuse wheezing , and a friction rub at the right base. Chest x-ray obtained at that time revealed bilateral infiltrates, left greater than right,

with a large round infiltrate in the left upper lobe and a right pleural effusion. ABG's on 2 L showed a p02 71, pC02 35, and pH 7.51.

At this point, Pulmonary was consulted. Repeat chest x-rays showed worsening infiltrates and the development of a cavitary lesion in the left upper lobe. Bilateral decubitus films showed no layering of the pleural fluid and due to her worsening respiratory status, she was felt to be too unstable to undergo bronchoalveolar lavage. Erythromycin was added for additional coverage, and a CT scan of the chest was performed. The initial reading revealed large atelectatic areas in the mid and upper lung fields, a bilateral pneumonic process, and a right pleural effusion. There were some small one cm lymph nodes in the AP window and anterior to the trachea noted.

Over the next five days her WBC increased to 2,300, although her pneumonia continued to worsen. She then developed a rash consisting of tender erythematous nodules predominately over her lower extremities with some involvement of her left arm. Her mental status around this time began to deteriorate and she developed complex partial seizures. A CT scan of the head revealed areas of low attenuation in the right cerebellum, right frontal lobe, and brain stem all of which enhanced with contrast. She was treated with Dilantin and her seizures resolved.

At this time a diagnostic procedure was performed.

Dr. Duddleston: I will start by resummarizing this singular case of dread disease. This is a 57 year old leukemic that had a repeat induction after relapsing. On day two of hospitalization, the patient had a febrile episode and at that time empiric antibiotics were started, including ceftazidime, ampicillin and clindamycin. On day ten, nausea and diarrhea occurred; this is common with mucositis as a result of the chemotherapy. On day fifteen, the patient had a recurrent fever while on antibiotics. At that time, more antibiotics were empirically added, in this case, Vancomycin. On day seventeen, the patient remained febrile and at that time Amphotericin was added. On day twenty-three, the patient continued to be febrile, developed shortness of breath, and developed focal bilateral infiltrates and mild hypoxia. By day twenty-four, the lesion possibly cavitated and at this point Erythromycin was added and a CT scan of the chest was done. Bronchoscopy was not done at this time because of the risk of respiratory failure.

On day twenty-nine, the pneumonia continued to worsen, the patient developed a rash, mental status changes, and seizures. Note that at this point the WBC had improved somewhat. At this point, a procedure was performed. I will now ask Dr. Barlow to review the x-rays, as I have not yet seen them myself.

Dr. Barlow: A chest x-ray early in the course of the illness revealed a rounded infiltrate in the right mid lung and a wedge shape infiltrate in the left upper lung region. Approximately one week later you can see there is progression of the disease with a larger rounded infiltrate in the right mid lung. A more consolidated appearance of the infiltrate is on the left. There is blunting of the right costophrenic angle suggesting development of a pleural effusion. Chest CT was obtained revealing large wedge shaped focal areas of consolidation. They extend to the pleural surface. There are a couple of 1 cm nodes in the paratracheal region and you can see there is a right pleural effusion. This reveals more of the same when you can see that there are air bronchograms on the right. Later in the course of the illness you begin to develop subtle curvilinear luciencies medial to the infiltrate. This is approximately three weeks into the course of the illness and at the time that the patients developed seizures, they obtained a contrasted CT of the head. There is a hypo-dense lesion in the right cerebellum, and there is minimal ring enhancement of this lesion. There is also a hypo-dense lesion with some enhancement at the medial right frontal lobe. There is more enhancement of the same lesion and an additional nodular enhancing lesion in the left frontal lobe that was not seen on the pre-contrast images.

Dr. Duddleston: This a neutropenic patient who has been having prolonged fever and a long duration of neutropenia. The poet John Donne wrote about the usual sense of roving hands upon women, but it applies to the physical exam in this patient:

"License my roving hands and let them go,
before, behind, between, above, below".

A thorough physical exam is essential in evaluating a complex patient with fever. Dr. Daly, can you tell us about what you did find on physical exam on this patient?

Dr. Daly: Hands roved, and she had multiple skin lesions that came up rather suddenly from one morning to the next. They were very tender, erythematous, raised nodules in varying diameter predominately on her lower extremity, as the accompanying photograph depicts.



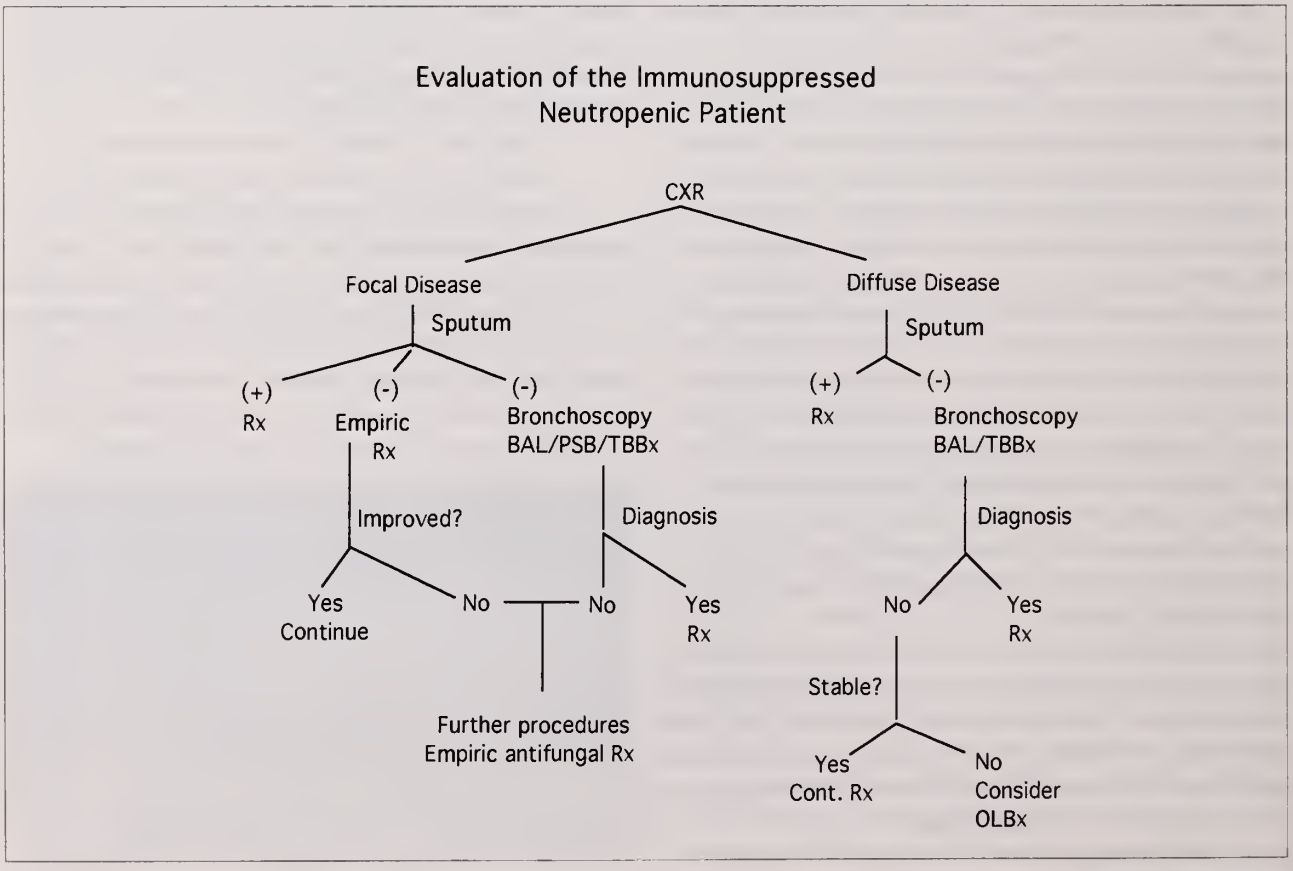
Dr. Duddleston: I want to describe these lesions a little bit further. This is on the calf of the patient and you notice that there are well circumscribed round, red macular areas with a raised purple lesion in the center. Other lesions were scattered on the extremities throughout.

Let's review the approach to the patient[1]. First, careful, frequent physical exams are important on this type of patient, because you will often pick up significant findings. Second, after initial cultures are done, empiric therapy is indicated[2]. You then await a response to empiric therapy while planning contingencies for treatment failure. What I mean by that is that you watch the clock for about 48 to 72 hours. If the patient is not improved, deffervesced with his fever and improved clinically, then it is time to pursue diagnosis further. This usually involves invasive procedures.

This patient had pneumonia; early pulmonary procedures were contemplated in this patient, but were not done because the patient was unstable by that point. Procedures considered early in this case could have included induced sputum collection, bronchoscopy or open lung biopsy, with culture of appropriate sites. Further treatment is based on the findings or lack of findings; you add or change therapy. The following algorithm[3] is helpful in evaluating an immunosuppressed neutropenic patient (see figure).

At the top of the algorithm is chest x-ray results. When a patient presents with pulmonary symptoms, you often get a chest x-ray and that will indicate whether you have focal disease or diffuse disease. On the right side of this decision tree is diffuse disease. On either side, the first thing you do is look at the sputum. If the sputum is negative in diffuse disease, you go directly to bronchoscopy with bronchoalveolar lavage and transbronchial biopsy. If at that time you have a diagnosis, you treat it. If you don't have a diagnosis and the patient remains stable, then you continue on empiric therapy. If you do a bronchoscopy and the patient is unstable, you consider an open lung biopsy in that patient.

In focal disease, you look at the sputum. If you can't get sputum that the patient coughs up on their own, you can do an induced sputum. Usually, you use 3% saline as a mist that irritates the trachea and bronchi and causes the patient to cough up something. If you don't get anything on sputum, you go directly to empiric therapy. If the patient improves, you continue on empiric therapy in this case. If the patient does not improve or if you think that a procedure is possible at that time, then you go to bronchoscopy with the same procedures as above; bronchoalveolar lavage, protected brushings, and transbronchial biopsy, if the patient will tolerate that. If you get a diagnosis there, you treat it. If all of these are



negative, then you either go to further procedures (such as open lung biopsy) or empiric antifungal therapy.

In this case, no procedures were done and the patient was begun on empiric antifungal therapy at a dose of 0.5mg/kg/day.

We're going to talk on empiric therapy. One of my favorite old weapons is a blunderbuss: a short gun that had a large bore and a bell muzzle capable of holding multiple balls, intended to fire at close range without exact aim. That's the definition of empiric therapy: to aim, but not exactly.

Empiric therapy used in this case was Fortaz, Ampicillin, and Clindamycin. These broad spectrum antibiotics are the cornerstone of treatment in early febrile illnesses in early neutropenic patients[4]. Other regimens include ceftazidine by itself, an anti-pseudomonal penicillin plus aminoglycoside, and imipenem[5]. In this case, the ceftazidime would treat pseudomonas, gram positives, gram negatives, and some anaerobes. Ampicillin will treat enterococcus. (Remember, the patient had mucositis earlier.) Clindamycin would cover, in addition to the others, gram positives, B-Fragilis and other anaerobes. On day 15, Vancomycin was added and this will treat Methicillin resistant staph, so we have all of those covered at this point. On day 17, Amphotericin was added at 35mg/day, which is .5mg/kg/day. This dose is sufficient to treat Candida. On day 24, Erythromycin was added and this will protect against Legionella, Mycoplasma, Chlamydia atypicals. However, in this case, the pneumonia remained refractory.

We classify pneumonia in neutropenic patients based on their presentation clinically[6]. In this case, focal disease was present, not diffuse disease. That is determined on the initial chest x-rays. I really refer to fever and respiratory symptoms or findings within the first seven days of neutropenia.

"Refractory" refers to the syndrome I discussed above. If you wait 48 to 72 hours after the initiation of empiric antibiotics and the patient continues to have findings, that is refractory pneumonia or fever.

"Late", which is the case here, is after 7 days of neutropenia the patient presents with new infiltrates.

I believe this patient represented a late focal pneumonia. In early focal disease, bacteria are the most common cause; that is why empiric antibiotic therapy is started immediately after obtaining cultures. Refractory pneumonia can apply to a wide range of illnesses, and late is usually fungal.

We will now discuss the differential diagnosis. As I grew up in legalistic atmosphere, I felt that a disclaimer was necessary:

"I am a Bear of very little brain,
and long words bother me"
-- Winnie the Pooh.

I have the differential narrowed down now to just a few major categories: Fungi, bacteria, mycobacteria, and parasites! I left off viruses in this case because I think that prolonged infection with a virus at this point would have consumed the patient before two weeks was up. In the fungi category and molds, we have aspergillus, Fusarium, histo, Candida, Mucor, Zygomycetes, and Cryptococcus. Bacteria, which you recall would have to be resistant to the armamentarium of antibiotics to this point, could include resistant staph or resistant gram negatives such as Pseudomonas, Aeromonas, atypicals, and Nocardia. Nocardia could slip through the net of all the antibiotics used. Tuberculosis or other atypical mycobacteria usually cause diffuse lung disease.

I focus my differential diagnosis to the following: Aspergillus and Mucor can cause lung disease in neutropenic patients, with brain metastases and brain abscesses and can also cause skin lesions. Pseudomonas and Aeromonas are relatives that may cause similar syndromes. These organisms cross the usual barriers that we have and therefore can cause this wide array of lesions. Nocardia is present in the focused differential, as are mycobacteria.

The procedure that was done likely was a skin biopsy. I do suggest that an open lung biopsy should have been done because I want to make it clear that this patient may have been a candidate for a procedure early on in the course, before she became unstable. The bronchoscopy that we talked about in this patient may have been risky. Any patient that has impending respiratory failure should not have a bronchoscopy done, although typically the bronchoscopy and the associated procedures are low risk[7]. If the patient is in impending respiratory distress or failure, the bronchoscopy may have to be delayed. If in that case the patient does develop respiratory failure, and I am not sure if this patient was on a ventilator or not, the patient would be placed on a ventilator. If the FIO2 is less that 50% and PEEP is less than 10, then the bronchoscopy can be performed safely through the endotracheal tube during mechanical ventilation[8]. This patient did not progress to that point, but one last thing to consider is an open lung biopsy, which can be performed in unstable patients. The only contraindication to this is if the patient has unsupportable thrombocytopenia and bleeding diathesis. The other risks associated with open lung biopsy are controlled during surgery and postoperatively, so that the risk of the procedure is felt to be quite low. We associate a high mortality with open lung biopsy, but that

is probably because of the underlying disease of the patient and not because of the biopsy itself[9].

I believe this patient had a skin biopsy. The patient had the appearance of skin lesions late in the course and skin biopsy is useful in making diagnoses in neutropenic patients. Skin biopsy is helpful in about 50% of the time in making a diagnoses in this type of case[10]. In this situation, the approach to the patient is what I want to target. Open lung biopsy or a lung procedure may have produced an accurate diagnosis in that patient's lungs, yet a skin biopsy could be useful if you believe the same illness is responsible for both lesions. If the patient is felt to be too unstable, then you take your chances on not getting an accurate pulmonary diagnosis from the skin. I would say if the patient's condition and the patient's life is dependent on a procedure, go where the money is. The money in this case was in the lungs but since we had the skin lesions, I couldn't resist and I think that's what was done.

My diagnosis, and it is about a 50/50 toss up, is between aspergillus and Nocardia. Aspergillus is one of the most common diagnoses in a neutropenic patient with late pneumonia and, as we discussed, the amphotericin B was not at a dose high enough to suppress aspergillus. Aspergillus is usually treated with Amphotericin B in doses of 1 mg to 1.5 mg/kg per day and this patient was on half that dose[11]. Aspergillus often comes through despite low doses of Amphotericin B, as this patient had. As I said, it will cover Candida, but not aspergillus. Candida can cause all of the symptoms of this patient, but it should be killed by the Amphotericin. Aspergillus can cause the brain abscess, lung disease, and skin emboli. The skin lesions pictured are embolic; as I noted, they were purple on the inside with a pustular center. The center is usually an area of necrosis that fungal diseases will break down into black eschar and can be diagnosed by skin biopsy[12].

Nocardia can also slip through the armamentarium that was used. Nocardia is usually treated by sulfonamides, usually Bactrim in high doses. If that fails or if the patient is allergic, the patient can be treated with aminoglycosides and imipenem or could also be treated with other combinations including ampicillin plus erythromycin[13]. This patient had partial coverage with nocardial treatment but in this case may not have been enough.

Being adventuresome, I avoided aspergillus as my diagnosis and decided that patient may have Nocardia sepsis with pneumonia, septic brain emboli, and a decription of ecthyma gangrenosum. Sue, I will turn it back to you. I await my verdict.

***Dr. Walker*:** The patient's lesions, as shown in the photomicrograph of her right posterior calf, were hot, tender erythematous nodules. A skin punch biopsy of one of these nodules showed a normal stratum corneum, epidermis and papillary dermis. The deep reticular dermis showed a perivascular inflammatory infiltrate which was primarily acute inflammatory cells. These were mature myeloids rather than a leukemic type infiltrate. The subcutaneous fat showed an intense acute inflammatory cell infiltrate. It is very deep with some tissue necrosis and abscess formation. Closer examination of the panniculus revealed numerous hyphal elements within the inflammation and necrosis.

The differential in an attempt to characterize and classify these fungal elements would include three categories: the dermateaceous fungi, the Mucorales group, and the aspergillus group of fungi. Any of these groups may be associated with the disease and clinical findings of this patient. However, the dermateaceous group produces pigment which can almost always be seen on an H & E preparation, and careful search of this specimen failed to reveal pigment formation.

The Mucorales group tend to have rare septae, broad hyphae, right angle branching, and "edge" staining on GMS. Also, these are seen more frequently in acidotic patients, and are associated with vascular invasion.

The aspergillus groups tend to have more narrow hyphae, frequent septae, narrow angle branching, and solid wall staining on GMS. The aspergillus groups are frequently associated with patients who are, for one reason or another, immunosuppressed.

The fungus seen in the skin biopsy from this patient showed narrow hyphae, frequent septae, and narrow angle banding. The Gomori Methenamine Silver stain confirmed frequent septae and narrow hyphae with a more consistent staining across the cell wall rather than staining only the lateral edges and making the hyphae appear hollow, as the Mucorales group frequently does.

In conclusion, the characteristics of this fungus are most consistent with the Aspergillus group.

***Diagnosis*: acute panniculitis secondary to fungal infection, most likely Aspergillus species.**

Further follow-up:

Dr. Daly: Exactly as Dr. Duddleston had mentioned, we had an Infectious Disease consult and they recommended that we treat her with the higher dose Amphotericin. She did not respond to two weeks of that regimen. Her clinical picture continually deteriorated and she eventually wanted to have all support withdrawn and to be sent home. She expired soon after discharge, at home. ❑

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***Drs. Guynes, Huey** and **McMullan** were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center 1994-95.*

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Address of the President MSMA House of Delegates-May 2, 1996

Mister Speaker, fellow officers and members of the Board of Trustees, members of the House of Delegates, Dr. Corlin, and guests, I thank you all for the unique privilege of serving as your President, for this has truly been one of the most enjoyable and rewarding experiences of my life.

This year, I have been enriched by hundreds of physicians and their spouses I have met from all over the state.

I have also had the opportunity to gain a perspective about organized medicine and how we as physicians relate both to each other and to those outside the profession.

This morning I would like to share briefly some of my perspectives from this past year as President of your association.

One of the most enjoyable duties of the President is to visit with each of our component societies during the year. At each of these gatherings I was treated with unfailing civility, much like the political candidate in one of our western states who visited an Indian reservation in pursuit of votes and was given permission to speak to the tribe.

"If elected," he said, "I'll get schools and hospitals (and perhaps even a casino) for your people."

"Goomwah!" shouted the crowd. "You'll have gas heat and running water (and maybe even a computer) in every teepee," he promised. Again the tribe shouted, "Goomwah!"

After the speech, the chief said to him, "You're a good friend to the Indian. Please come into the corral so we can present you with a fine pony. But be careful and don't step in the goomwah."

I guess my situation may have been similar to this politician's, even though no one ever yelled 'goomwah' during one of my addresses. You might not have agreed with everything I said, but you welcomed and honored me anyway, and for that I am extremely grateful.

I think it is difficult for one to spend any amount of time in a leadership position in organized medicine today without feeling a sense of both joy and sadness.

There is joy in seeing your colleagues come together in a spirit of cooperation to deal with the many problems and challenges that confront us each day, whether it be serving patients better or retaining autonomy in a delivery system that seems to have a mind of its own.

But there is also sadness — a sadness that comes from seeing our medical organizations struggle to survive in the face of declining interest.

Although no level of organized medicine appears immune from this problem, it seems especially critical at the component society level. At practically every society meeting I attended during the past year I heard one or more of its members bemoan the poor attendance and lack of participation.

Much of the problem may have to do with how the practice of medicine has changed. As one old man was overhead saying to another, "the trouble with our time is that the future is not what it used to be."

No one can deny that these are challenging times and the extra effort it takes just to keep up with everything occurring in our medical practices often comes at the expense of participating in our medical organizations.

The corporate bureaucratization of health care and uncertainty about the future make all of us anxious and increasingly frustrated.

If you're like me, you frequently feel like the Australian bushman who got a new boomerang and spent the rest of his life trying to throw away the old one.

So what happens? Rather than

attend our local medical society meeting we go home at night and become the man who answered a questionnaire that asked, "What is the greatest public problem — ignorance or apathy?" by responding, "I don't know and don't care."

To the contrary, it has become increasingly clear to me over this past year that we need organized medicine at all levels — local, state and AMA — more now than ever before. Without it we are like a symphony without a conductor.

At one time or another I know each of us has heard a symphony orchestra warming up prior to its performance. Surely there has never been a more undirected, discordant sound.

But as soon as the conductor arrives and takes control of all those individual musicians by coordinating their talents — what glorious harmony it becomes!

We in the medical profession are much like a symphony orchestra. We have our prima donas, our artistic temperaments, our different training by specialty.

But I'm sure you will agree that just as symphonic success depends on the coordination of individual musicians, so the ultimate success of American medicine depends on physicians realizing that — as diverse as we are — we must work together and have the right conductor to lead us.

That conductor is our local and state society and the AMA, all of whom are working in concert to unify the family of medicine and transform discord into harmony and concert.

One of the most widely quoted people in America may be former New York Yankee catcher Yogi Berra, who has given us a wealth of memorable malapropos.

One of my favorites was when someone asked Yogi if he wanted his pizza cut in eight or 12 slices. After thinking about it for a minute he said, "well, you'd better just do eight because I'm not that hungry."

During his term as our President two years ago, my good friend Don Mitchell used another of Yogi's renderings in his remarks to the component societies.

Don quoted Yogi's now famous saying that "When you come to a fork in the road — take it" to remind us that we were facing a choice about what direction we as a profession and as a medical society could take.

We could take the road of resisting the changes that were happening all around us, or we could recognize the inevitability of change and attempt to shape and manage it.

I think we have now come to another very large fork in the road and we need to make a decision about where we want to go.

In my opinion, the most significant problem confronting us over the next several years is the breakdown of professional unity. Sometimes we seem like the army that organizes a firing squad by forming a circle.

During this year's legislative session we had a situation arise in which two major specialty groups were on opposite sides of an issue. Much to their credit, representatives of both groups sat down and worked things out before it became a public squabble — but this disagreement is only one outward sign of an internal professional struggle that is becoming more and more evident.

My greatest wish is that we would all realize that we are not each other's enemy. The real enemy is the growing belief that less care or cheaper care is better. The real enemy is embracing a system that is driven by profits and not patients. And the real enemy are those who would have us believe that receiving medical care by someone other than a physician is not only acceptable, but in some instances preferable.

I think the epitaph of our professional generation will be written on the basis of how we deal with the issue of unity.

A hypochondriacs gravestone in one our cemeteries is inscribed with the words, "I told you I was sick"!

Similarly, I hope our place in history is not remembered with the words, "We told you to stick together"!

As President of your association I had the opportunity to see the inner workings of our legislative program "up close and personal", as they say. And what an experience that was!

It is impossible to be closely involved in our legislative activity without realizing how crucial it is for every member of the association to be just as involved.

Now, I know that all too frequently many of us view the legislature, or anything political, with disdain. That is not endemic to the medical profession.

In fact, during the waning years of the Continental Congress in early 1776, those who supported severing our ties with Britain had grown weary and frustrated with the refusal to adopt the Virginia delegation's resolution declaring independence from the crown.

One day that great patriot, John Adams, became so enraged with the delay and indecision that he announced to his colleagues in the congress that he had come to the conclusion that one useless man should be called a disgrace; that two useless men should be called a law firm; and that three or more useless men should be called a legislature.

Regardless of what our perceptions about the legislature may be, the simple reality is that it can leave us alone, it can do something

for us, or it can do something to us. And we have the power essentially to decide which of those things it does.

Ours is a representative government, and the cornerstone of representative government is communication. If we communicate with those who represent us in government better and more often than our detractors, then we will be successful. If we don't, then we won't. It's as simple as that.

Grassroots involvement is the name of the game and if we don't take the time to become involved we have no one to blame for the consequences but ourselves.

Unfortunately, it is not at all uncommon to see the walls of a legislative committee room lined with our opponents on a particular bill while we are represented solely by our good and faithful lobbyist, Charmain.

I plead with you, when you return home urge your colleagues to get involved in our legislative program by communicating with your elected representatives when we ask you to. And if we ask you to come to the Capital, please do so. The process of influencing the passage of laws is simply too important to each of us to leave to someone else to do.

On Sunday, I will turn over the helm of your association to the capable hands of Fred McMillan and I will join the ranks of our Past Presidents. Like many of them, however, I intend to stay actively involved in the association. To do otherwise would betray the trust you have bestowed upon me by allowing me to serve as your President.

As a matter of fact, I prefer to be like former Louisiana Governor "Uncle" Earl Long, who said that when he died he wanted to be buried in a cemetery in a notoriously corrupt parish in southern Louisiana so he could stay active in politics.

And now for a point of personal privilege, I want to thank my partners for their understanding in my being out of the office as much as I have; my nurse, Joy, who is here with her husband, John Munn — she is indeed aptly named for she is a true joy to work with and can find something good in any situation; the MSMA staff for their invaluable assistance — and I think that we're all still friends; and all of you for honoring me as your President.

Finally, I want to recognize my family who are here with me this morning: my loving and supportive wife Beth; my daughter Julie and her husband Kevin Humphreys, who will now have to address me as something

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other than "El Presidente!"; and my daughter Laura and her husband Derek Dyess, who added to the excitement of the year with their wedding in December.

Laura and Derek had dated for five and half years, and early on in their courtship Derek was diagnosed with leukemia. It was a joy to watch as their relationship was blessed and their commitment to one another deepened and matured.

Laura now teaches third grade at the Mississippi School for the Deaf in Jackson. And Derek — well, he's in remission and is completing his first year of medical school at UMC where he is still amazingly enthusiastic about everything.

I would like to think that my presence in Derek's life had some influence on his choice of medicine as a profession. I know beyond a shadow of a doubt that his illness will make him a more compassionate and caring physician.

And even though I may not recognize the practice of medicine in another 10 or 15 years, I would hope that what I'm about — and what you're about — on behalf of organized medicine will make a difference down the road for Derek and his generation.

Thank you.

D. Stanley Hartness, M.D.

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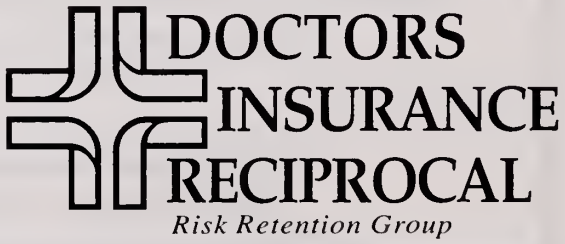
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The President's Page

What Did I Learn

A couple of days after returning from the MSMA Annual Session on the coast one of my cohorts asked me the question, "Well, what did you learn at the meeting?". My initial response was somewhat vague and I pondered his question the rest of the morning. The following is my more thoughtful answer.

To coin a phrase often used by Dr. Norman Nelson, your MSMA is alive and doing well. Membership is up, participation is up, and the benefits of membership are up. There was a total membership in 1995 of 3,010 which included an increase of 67 paid members. Approximately three-fourths of the actual practicing physicians in Mississippi belong to our MSMA.

Participation in the annual meeting was enthusiastic. We were meeting at one of the new facilities on the coast. The program was excellent. There were over 500 persons in attendance which included 236 MSMA members and guests.

The Alliance also had an increase in participation and they continue to expand their very worthwhile programs - AMA - ERF, S.A.V.E., and HealthChoice are three. More on the Alliance in another article.

Participation is up partially due to the best meeting site we have had in years. The coast is coming back with great facilities, service and tourist attractions. I feel participation is also up because physicians are reacting to the need for a strong collective voice in dealing with the changes in how patients will access health care.

This brings me to the third thing I learned on the coast. Our MSMA is responding proactively to these changes. The Council on Medical Services has studied the issues of nurse practitioners and physician assistants. The Council reports that the Joint Practice Committee consisting of physicians and nurses is doing an excellent job along side the licensure boards

of physicians and nurses in making sure the protocols are working. The Council of Medical Services reports its review of physician assistants show they have a commitment to dependent practice and that giving them the ability to practice under direct supervision of physicians should continue to be pursued.

I learned that the AMA's - Organized Medical Staff section which meets bi-annually is an excellent forum for education and policy discussion on all matters affecting the medical staff. We need the participation of at least one physician from each hospital in Mississippi in this section. Check with Rodney Frothingham, M.D. on the dates.

I learned that Mississippi Physicians Care Network, our managed care company, continues to grow and increase in its success adding another 500 physicians and 30 hospitals to its membership. Also, it has increased its covered lives to 100,000. MPCN is setting the standard which other networks in Mississippi will have to meet in order to be successful in our state.

I learned that the leadership in our state medical association wants to be sure everyone has an opportunity to voice an informed opinion on being unified with the AMA. At the annual meeting the Board of Trustees sought and received from the delegates authority to implement a plan in accomplishing this.

MSMA continues to encourage more widespread use of medical savings accounts. We have pursued this legislatively and are considering this as a product of our managed care plan when feasible.

So what did I learn? I learned that the annual meeting this year was informative, responsive, and fun. You should try it!! Same place, May 14-18, next year!!

Fred



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AIR FORCE

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVII, NUMBER 6
JUNE 1996

ONLY POSITIVE MISSISSIPPI SPOKEN

Just prior to the MSMA annual session this spring I took a long self-promised trip to Shiloh. This, of course, involves passing out of state, and it was then I observed the sign at the state line, "Only Positive Mississippi Spoken." Mississippi, a language? Nahh, I scoffed. But then as the car retraced our army's retreat to Corinth, I began thinking. And the more I thought, the more distinctive our speech seemed.

I grew up in Louisiana (where Mississippi is spoken of in the same whispered tone reserved for the Third World). Louisiana certainly has its own Cajun speak and New Orleans street talk--all necessary to know when working the West Admit Room of Charity Hospital. And residency training in Birmingham allowed me to learn Alabama hill talk. Some phrases are common to both Alabama and Mississippi. "He ain't of no account" describes the same thing in both states, a doctor who wasn't available to take call for another when he promised to be (the Louisiana form of this is unprintable). But Mississippi does have a uniqueness.

Several weeks after setting up practice in Natchez I saw a patient referred from another physician for elevated liver enzymes. "I'm all stove up," was all the patient could say when asked what bothered him. It took twenty minutes of wrangling with the man before I learned that "stove up" meant stiff from arthritis. The leap from there to the autoimmune complications of Hepatitis B wasn't hard. However, nowhere in Harrison's Principles of Internal Medicine (trust me on this) does the word "stove" appear. Once in Mississippi, one is on his own.

One time was enough on "stove," but seventeen years into practice and I still stumble over the next one. Just slip up once and ask a patient where the pain is and watch him rear back, shaking his head to correct immediately a colossal oversight. "It's not a pain; it's a hurt," he says with passion, fingers digging at the afflicted spot. Again to Harrison's. Beyond the noun-verb difference, there seems to be no distinction between the two words, except In Mississippi--and you'd better get it right or someone will think you haven't been listening.

Other phrases are just as necessary to know. If a patient is "sick," that's serious enough. But if he is "low sick," well, John-Boy, you'd better get down the hall and into that room. It is a mere annoyance if someone's nose is "running like a spring branch," but if it's "running hot scalding water," this is a more serious situation. Things will go better at that point if you straighten up a bit and avoid rubbing your eyes.

Other colorful phrases abound. Don't ask a man whether he gets faint when rising quickly from a chair, and, for heaven's sake, don't say the word orthostasis. Just ask if he's had the "blind staggers" and he'll know immediately what you mean. "I might as well have drunk stump water," a man said of the medicine I had given him. A woman told me she felt as if a nest of kittens had been down in her chest since Christmas--she had bronchitis. Another said she felt as if she had a swelled-up bean sprout in her lower belly-- she had diverticulitis. I have yet to figure out what having a "skim" over the eyes means, but I will.

I remember clearly the woman who rambled on through my attempts to ask questions, then stopped and said, "You know, my father used to tell me how an empty wagon makes a lot of noise. I'm gonna hush up now and listen to you." And I remember the old man whose eyes darted at me when I asked about what I calculated would be a weak urinary stream. He wasn't exactly writing his name on the wall, he allowed in a proud grizzled voice, but he was managing.

And finally there is the phrase that cannot be peculiar to our state, but that I've heard, I'll swear to you, only once--in Mississippi. It came from a young woman on whom I was performing a sigmoidoscopic exam. After a twist, a turn, and a grunt, she managed to turn her head and look me squarely in the eye. "Your five minutes are up," she said evenly. Fluent by then in Mississippi, I terminated the exam, and was right smart quick about it, too.

Leslie E. England, Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

MSMA 128th Annual Session



Fred L. McMillan, MD, of Jackson, center, was installed as 1996-97 MSMA President during the closing session of the MSMA House of Delegates on Sunday, May 5. H. Vann Craig, MD, of Natchez, left, was named president-elect. D. Stanley Hartness, MD, of Kosciusko, right, is immediate past president of the Association.

Dr. McMillan Installed as Association President; Dr. Craig Named President-Elect

Fred L. McMillan, MD of Jackson, an ophthalmologist in private practice, was installed as 1996-97 president of the Mississippi State Medical Association and **H. Vann Craig, MD** of Natchez was named president-elect during the closing session of the 128th MSMA Annual Session held May 1-5, 1996 in Biloxi, Mississippi.

Dr. McMillan, a member of the association since 1974, has served the Association as a member of the Board of Trustees of which he has served as secretary-treasurer, and as an alternate delegate to the AMA. He is a past president of the Central Medical Society, Jackson Opthmological Society and the Mississippi Ear, Nose and Throat Association. Upon completing his internship and residency at the University of Mississippi School of Medicine, Dr. McMillan completed fellowships at the Bascomb-Palmer Eye Institute and the Vitreo-Retinal Research Foundation.

Dr. Craig, a Natchez surgeon, has been an active member of the association since 1962 having served as speaker of the House of Delegates, and as a member of the Board of Directors for the Mississippi Foundation for Medical Care. He is an alternate delegate to AMA.

Newly Elected Officers, Board & Council Members

Serving as MSMA Board members and officers during the 1996-97 association year will be: Michael H. Carter, Jr., MD, Greenwood, Chairman; Julian C. Henderson, MD, Jackson, Vice Chairman; Dewitt G. Crawford, MD, Louisville, Secretary; Ben M. Carmichael, MD, Hattiesburg; William A. Spencer, MD, Oxford; Leonard H. Brandon, MD, Starkville; John J. Cook, MD, Jackson; Chester W. Masterson, MD, Vicksburg; Hal Moore, MD, Pascagoula; Fred L. McMillan, MD, Jackson, President; D. Stanley Hartness, MD, Kosciusko, Immediate Past President; H. Vann Craig, MD, Natchez, President-elect; and Candace E. Keller, MD, Hattiesburg, Secretary-Treasurer. Mrs. George R. (Nancy)Bush, President of the MSMA Alliance will serve as the Alliance representative to the Board.

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H. Vann Craig, MD, Natchez
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George E. McGee, MD, Hattiesburg
Vice Speaker of the House
Daniel P. Edney, MD, Vicksburg
Delegate to the AMA
George E. McGee, MD, Hattiesburg
Alternate Delegate to the AMA
Michael H. Carter, Jr., MD, Greenwood
Delegate to the AMA
William C. Gates, Columbus
Alternate Delegate to the AMA
Nancy O. Tatum, MD, Jackson
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Mal Morgan, MD, Natchez
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Council on Public Information, District 6
John F. Hassell, MD, Laurel
Chairman, Surgery Plenary Section
Bobby J. Heath, MD, Jackson

Actions of the House of Delegates 128th Annual Session

MSMA's House of Delegates considered reports from the Board of Trustees and Councils as well as numerous resolutions.

Delegates elected by MSMA's component societies considered the reports and resolutions.

Among actions taken by the Delegates were the following:

- Noted and commended the growth of the Mississippi Physicians Care Network which during the year had increased its physician network membership by 40 percent, its hospital network membership by 100 percent and had contracted with employer groups totalling over 100,000 covered lives.

- Referred to the Board of Trustees a report requiring a decision on a method to determine physician support for unified MSMA/AMA membership and a vote by the House of Delegates in that regard.

- Increased MSMA dues by $40 to $350 effective with 1997 dues noting that MSMA dues had last been increased in 1993, that general costs of doing business had increased since then, and that average state medical association dues were currently $399.

- Noted that the association had successfully supported legislation during the 1996 Regular Session of the Mississippi Legislature which revised education and regulation requirements for physicians' employees taking x-rays, avoided reductions in Medicaid reimbursement for physicians' services, and established a plan to implement medical savings accounts for state employees and teachers.

- Received for information a plan for the association to determine support for a single Medicare fee area for the state.

- Commended reestablishment of a committee composed of physicians and nurses to study and recommend the status of joint practice arrangements.

- Directed that MSMA provide health insurers in Mississippi with "Guidelines for Prenatal Care" which address hospital stays of mothers and newborns.

- Directed that MSMA furnish component societies with information on AMA membership requirements for medical missionaries and assist them with applications for AMA membership.

- Noted that membership had increased to 3,010 members in 1995 to include 67 new members.

- Urged the Mississippi Physicians Care Network to investigate the feasibility of offering a medical savings account product.

- Directed that MSMA support funding during the 1997 Regular Session of the Mississippi Legislature to allow expansion of the State Department of Health's Hepatitis B vaccination program to all children.

- Endorsed regulations of the U.S. Food and Drug Administration restricting access to tobacco products by minors.

- Urged that the MSMA membership be encouraged through the *Journal MSMA* to report class/group one communicable diseases to the Mississippi State Department of Health.

- Directed that MSMA support a coalition for a Tobacco Free Mississippi composed of interested organizations and groups.

- Directed that MSMA encourage and support an independent evaluation of the Mississippi Medicaid pilot HMO program.

- Adopted AMA Guidelines for Physician/Physician Assistant Practice.





Above, **H. Vann Craig, MD**, Natchez, and **George E. McGee, MD,** Hattiesburg, chaired the House of Delegates as Speaker and Vice Speaker respectively.

Left, **Stanley Hartness, MD**, presents the president's annual address to the MSMA House of Delegates.



Candace Keller, MD, Secretary-Treasurer of the Association, addresses the MSMA House of Delegates.



Richard F. Corlin, MD, of California, Speaker of the AMA House of Delegates, addressed the MSMA House of Delegates.



Dwalia South, MD of Ripley, North Mississippi Medical Society delegate, poses a question in the House of Delegates.



MSMA members from throughout the state attended the meeting and discussed current issues of importance to medicine during meetings of the House of Delegates and Reference Committees.

What

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Jeffrey Dean Noblin, MD, left, was the recipient of the Medical Assurance Company of Mississippi House of Delegates15th Annual Robert S. Caldwell Memorial Award. The award was presented by **R. Faser Triplett., MD**, MACM President, right. The Caldwell Memorial Award is presented by MACM each year, in the interest of furthering medical-legal education in Mississippi and in memory of Robert S. Caldwell. Dr. Caldwell, a surgeon from Tupelo, was instrumental in MACM's formation. He was MSMA's president-elect at the time of his death.



Jim McIlwain, MD, of Jackson, left, medical doctor of the Mississippi Foundation for Medical Care presented the annual MFMC Derrick award to Dr. George Abraham of Vicksburg. The award is given to the physician who provides outstanding physician support of the quality improvement program. Dr. Abraham has been a long-time supporter of the Foundation efforts, with particular emphasis on the past four years he served as treasurer and as chairman of the board.



Joe M. Ross, Jr., MD, right, is shown discussing a point at a meeting of the MSMA/ Mississippi Nurses Association Joint Practice Committee. The Council on Medical Services reported at annual session that the Joint Practice Committee is doing an excellent job along with the licensure boards of physicians and nurses in making sure the protocols are working.



Wallace Conerly, MD, left, Vice Chancellor of the University Medical Center, is accompanied by **Mrs. W.A. (Jeanne) Morrison,** right, and **Mrs. Hal (Melanie) Moore,** left, chairman of the Alliance's AMA-ERF Committee, as he receives the annual AMA-ERF award.

At right, **Richard F. Corbin, MD, Speaker of the House of Delegates,** is shown addressing the annual meeting of the MSMA Alliance.





During the annual Membership Party the MSMA Alliance held a silent auction to raise funds for AMA-ERF. The auction tables and easels were loaded with art, pottery, stained glass, quilts, specialty foods and crystal. **Bill Gates, MD**, of Columbus, left, one of the many artist who donated art for the auction stands beside his painting.

"The Practice Environment of Medicine" was the theme of the educational program held Friday and Saturday morning during the MSMA Annual Session. **Robert Rhodes, MD**, right, served as co-chairman of the program and is shown introducing the speakers at the Saturday session.





John Moffitt, MD, center, of Jackson also co-chaired the Plenary Program and is shown with **Henry G. Herrod, MD, Le Bonheur Professor of Pediatrics,** right, of Memphis and **Joseph W. Blackstone, MD**, of Gulfport, left.

John J. Cook, MD, of Jackson, and **Matthew Wesson, MD**, right, of Tupelo are shown during a break in the meetings of the MSMA House of Delegates. Dr. Cook was elected to the Board of Trustees for District 4 at the 128th Annual Session.





Alton B. Cobb, MD, left, of Jackson, and **Victor E. Landry of Lucedale, MD**, right, of Lucedale are shown during a break in the meetings of the MSMA House of Delegates.



Eric Lindstrom, MD, right, of Laurel, is shown visiting one of the many technical exhibits at the Annual Session.



Left, **Sidney O.Graves, Jr., MD**, of Natchez, far right, and **Ellis M. Moffitt, MD**, of Jackson, center, converse with newly elected **MSMA President Fred L. McMillan, MD,** of Jackson.

Dr. and Mrs. Stanley Hartness, MD, of Kosciusko are shown at the President's Dinner held during the annual session.





Fred L. McMillan, MD, of Jackson, enjoys one of the social functions during the annual session with guest Pat Clark from the AMA Federation Department.



Mal Morgan, MD, left, of Natchez welcomed **MSMA President Stanley Hartness, MD,** right, to the Past President's Breakfast.

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25th Annual Session Features Numerous Awards, HCQIP Update

The 25th Annual Session of the Foundation for Medical Care was held May 2 in conjunction with the State Medical Association convention in Biloxi. The session featured a guest speaker from Louisiana Health Care Review, the recognition of hospitals achieving outstanding results in quality improvement projects, the announcement of newly elected board of directors members, and the naming of the 1996 Arthur A. Derrick Award winner.

Dr. Livaudais Addresses Session

Dr. Gerard Livaudais, clinical coordinator for Louisiana Health Care Review, was quest speaker for the session. He presented an update from a neighboring PRO's perspective concerning the progress of HCFA's Health Care Quality Improvement Program.

In tracing the HCQIP program's development, Dr. Livaudais mentioned the need for physician buy-in and discussed the "why and what that encourages physicians to participate." He stressed the importance of: Knowing the customer; PROs/HCFA truly partnering; and PROs/HCFA practicing Total Quality Management (TQM).

He pointed out that proof and politics need to be strategically balanced and pursued through PRO programs, and he asserted that the absence of any proven vanguard for quality is still the best insurance for PRO program advancement.

Dr. McIlwain Announces Quality Award Winners

Foundation Principal Clinical Coordinator, Dr. James S. McIlwain, recognized Baptist Memorial Hospital-Golden Triangle Inc. in Columbus as the recipient of this year's Award of Excellence presented for outstanding achievement in continuous quality improvement projects. He also awarded South Central Regional Medical Center in Laurel with the year's Special Recognition Award given for achievement in a single continuous quality improvement project.

Newly Elected Board Members Named

Dr. McIlwain also named the 10 new board members: Drs. Leonard Brandon, Starkville; Charles F. Brock, Cleveland; John Cook, Jackson; Leslie England, Natchez; Hugh Gamble, Greenville; David Hall, Natchez; Karl Hatten, Clarksdale; Joe Hillman, Columbus; John Paul Lee, Forest; and Kenneth Reid, Meridian. They join returning board members: Drs. Tim Alford, Kosciusko; W. R. Arnett, Hattiesburg; Thomas Fenter, Brandon; Joe Files, Jackson; John Hassell, Laurel; William Henderson, Oxford; Francis Morrison, Ridgeland; Samuel Peeples, Jackson; Glenn Peters, Louisville; and Eugene Webb, Greenwood. Also recognized for their contributions to the Foundation were retiring board members: Dr. George Abraham of Vicksburg, who served as chairman for the past two years; Dr. Barney J. Guyton of Tupelo and Dr. Hardy Woodbridge of Jackson.

Dr. Abraham Receives Derrick Award

Dr. McIlwain named Dr. George Abraham of Vicksburg as the Derrick Award winner for providing outstanding physician support of the quality improvement program.

Dr. McIlwain noted the significance of the special presentation made in honor of Dr. Arthur A. Derrick of Durant, a former Foundation board member and chairman who had supported the program throughout its 25-year history. Dr. Derrick died in a car accident in March, 1993. "He is missed, but this honor given as a memorial in his name is an effort to remember his dedication to quality medicine," said Dr. McIlwain. He noted that Dr. Abraham has also been a long-time supporter of the Foundation efforts, with particular emphasis on the past four years when he has served as treasurer and as chairman of

the board.

Numerous committees, board of directors support and Foundation grassroots efforts have benefitted from Dr. Abraham's willingness to serve.

In private practice since 1978 at The Family Medicine Clinic, P. A., in Vicksburg, he founded the clinic in 1978. It was chosen to serve as a model clinic for first year Family Medicine residents from UMC, as they otate through the clinic on a monthly basis.

Since 1978, he has also served as clinical instructor in family medicine at UMC, as well as medical student preceptor at the Department of Family Medicine.

After attending Vicksburg Schools, he attended the University of Mississippi from 1960 through 1969, earning the B. S. degree in chemical engineering, the M. S. degree in nuclear engineering, and the Ph.D. in chemical engineering. Attending the University School of Medicine from 1971 to 1975, he received the M.D. degree Magna Cum Laude in 1975. Named outstanding senior medical student in 1975, he studied family medicine at UMC from 1975 to 1978.

His professional certification includes the American Board of Family Practice with added qualification in geriatric medicine, 1988 through 1998. The Physician Winner of the 1989 Patient Care Award for Excellence in Patient Education, he is active with numerous professional memberships.



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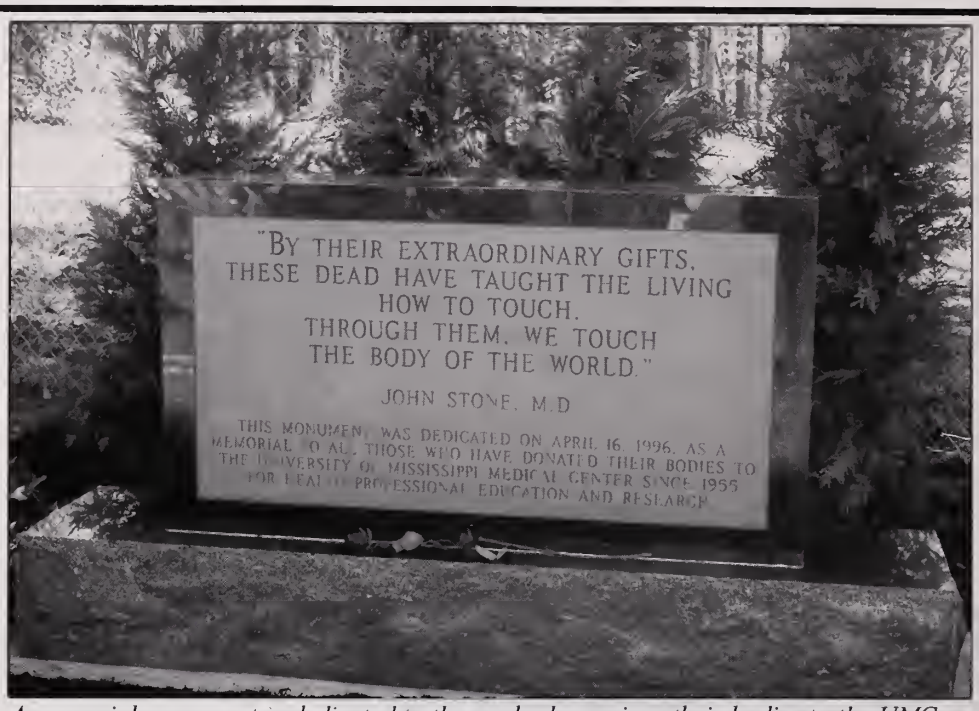
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A memorial monument is dedicated to those who have given their bodies to the UMC anatomical gifts program. It bears an inscription taken from a poem by Dr.John Stone. Stone is a cardiologist at Emory University, a poet and essayist and Jackson native. It reads, "By their extraordinary gifts, these dead have taught the living how to touch. Through them, we touch the body of the world."

Service Honors Those Who Benefit the Living Even in Death

Preston Jordan died as he lived--by giving things away. As his priest pointed out at his funeral mass, Jordan's job was giving away mail as a postal service employee. As a retiree, the job he liked most was giving food away in the church's out reach ministry. At his death, he gave his body. His church community, which celebrated his life of giving, did so without his physical remains. Jordan was one of hundreds honored and remembered Tuesday during a ceremony of appreciation for those who have donated their bodies to the Medical Center's anatomical gifts program. Their bodies are crucial in teaching health professional students human anatomy.

Students Julie Bird, occupational therapy Kent Logan, physical therapy, Kyle Odom and Andy Buntyn, dentistry, and Philip Blount, medicine, each expressed their gratitude on behalf of all the students who depend on body donations for their study of the human body. "Nothing takes its place," said UMC vice chancellor Dr. A. Wallace Conerly when asked by a reporter if technology had not supplemented the need for human tissue. "Technology has made great leaps in imaging, but nothing can come close to working with an actual human body."

Rabbi Steven Engel of Beth Israel Congregation and University Hospital clinical chaplain Dr. Ruth Black conducted the service, alternately reading prayers of consecration in the Medical Center cemetery where ashes of donors may now be buried. Chandler Thompson, opera per former and voice teacher at Mississippi College, sang two hymns acappella from the Christian and Jewish traditions. Students, faculty, staff and family members of body donors attended the noon service.

According to Dr. Tony Moore, associate professor of anatomy and director of the anatomical gifts program, donor families may have the ashes returned to them after about 18 months. If the family doesn't request the ashes, they will be buried at the new monument in the Medical Center cemetery.

The cemetery gate will be unlocked from 8a.m.-4:30 p.m. daily for relatives who want to visit the site and pay their respects at the final resting place of those individuals who were generous even in death.



Philip Blount, medical student, spoke on behalf of all the students who depend on body donations to understand human anatomy.

"It is evident by the number of students here that we are appreciative for the opportunity for hands-on learning. We are here to show how thankful we are that these people made such a generous choice, for our benefit, to the family members who respect their decision. We've all had an outstanding opportunity to learn how the body works and is put together. By having this priviledge we've learned anatomy and we've gained appreciation for God's beautiful handiwork. But we have also discovered something about ourselves, each other, life and death. It was once said, 'the greatest gift in human life is the gift of one's self'. Those people we honor here today, whose ashes are buried here, gave the gift of their bodies for our education. How grateful we are for their generosity and foresight!," *Blount said.*

Physicians' Recognition Award

Five MSMA members were named recipients of the AMA Physicians Recognition Award in May 1996. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Michael Francis Angel, MD
Delta Medical Society
Frank McVey Tilton, MD
Singing River Medical Society
Wilbert Joseph Manuel, MD
South Mississippi Medical Society
Marcos Ricardo Kornstein, MD
West Mississippi Medical Society
John Bayliss Ederington, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

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Personals

Two New Board Members Join Health Insurance Risk Pool



From left to right:Jan Lukens, MBA, CFP, a Gulf Coast consumer affairs specialist; Insurance Commissioner George Dale and Fred J. McDonnell, M.D.

Commissioner of Insurance George Dale has announced the appointment of two new members to the board of the Mississippi Comprehensive Health Insurance Risk Pool Association (MCHIRPA), a nonprofit entity created in 1991 to promote the availability of health and accident insurance for Mississippians who cannot obtain such coverage because of pre-existing medical conditions and one of the most successful programs of its kind in the U.S.

Jan Lukens, MBA, CFP, a Gulf Coast consumer affairs specialist, and Fred J. McDonnell, M.D. of Hazlehurst were sworn in as new board members during the pool's 1996 annual meeting on April 2.

Lukens is a Consumer Management Specialist with Mississippi State University's Cooperative Extension Service at its Coastal Research & Extension Center in Biloxi. McDonnell is a family practice physician and managing partner of Copiah Medical Associates. In addition, McDonnell serves as medical director of Pinecrest Guest Home and the Copiah County Board of Supervisors.

Lukens and McDonnell replace board members John Paul Lee, M.D. of Forest and former state Sen. Cy H. Rosenblatt of Jackson, whose terms of office expired this year. The pool functions as a "last resort" for persons who cannot buy health insurance because of pre-existing conditions.

John Patrick Barrett, M.D., has been elected Chief of Staff of the Medical Staff of St. Dominic-Jackson Memorial Hospital. Dr. Barrett will serve a two year term.

Earl E. Whitwell, MD was elected president of the Mississippi Orthopaedic Society during its annual meeting in Biloxi. Whitwell is a graduate of the University of Virginia. He received his medical degree and completed his residency program in orthopaedics from the University of Mississippi Medical Center. He has been practicing orthopaedics in Tupelo since June 1973.

R. Fulton Thompson, Jr, M D, of Tupelo, has become a Diplomate of the American Board of Anesthesiology.

Renee G.Wilson, MD, of Tupelo is now Board Certified in Internal Medicine.

Cardiology Associates of North Mississippi announces the formation of its new Tupelo-based group. MSMA members include: **Roland P. Guest, Jr., MD, FACC; Jack B. Foster, MD, FACC; David H. Irwin, Jr., MD, FACC** and **Michael J. Boland, MD, FACC.**

Paul M. Allen, MD, a Gynecologist and Obstetrician practicing in Pascagoula, has successfully completed a Surveyor Training Program conducted by the Accreditation Association for Ambulatory Health Care in Chicago, Illinois.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

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The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Jennifer Corson at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE
Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

INSURANCE/FINANCIAL/RETIREMENT PROGRAM
MSMA members have available several insurance plans designed exclusively for physicians. Through the "group" buying power of the association the plans can usually be obtained at lower cost and there is the advantage of "one stop" coverage. For further information contact Executive Planning Group.

MEDICAL MALPRACTICE INSURANCE
The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. The Company currently has 2000 policy holders. Extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

AMA Purchase Link - 800-772-4346.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - P.O. Box 5229, Jackson, MS 39296-5229, 601-354-5433 or 800-898-0251 (In-State-WATS).

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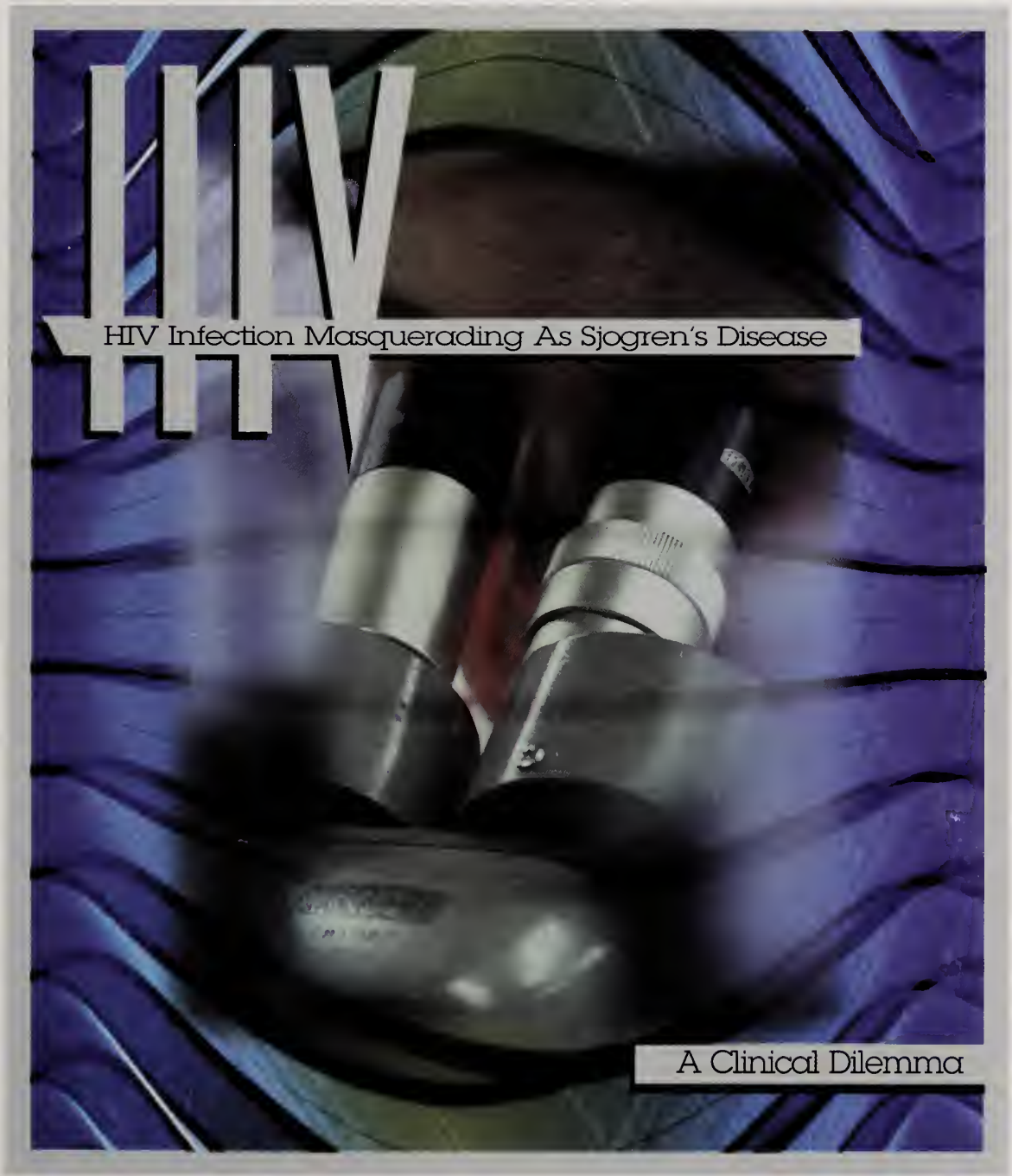
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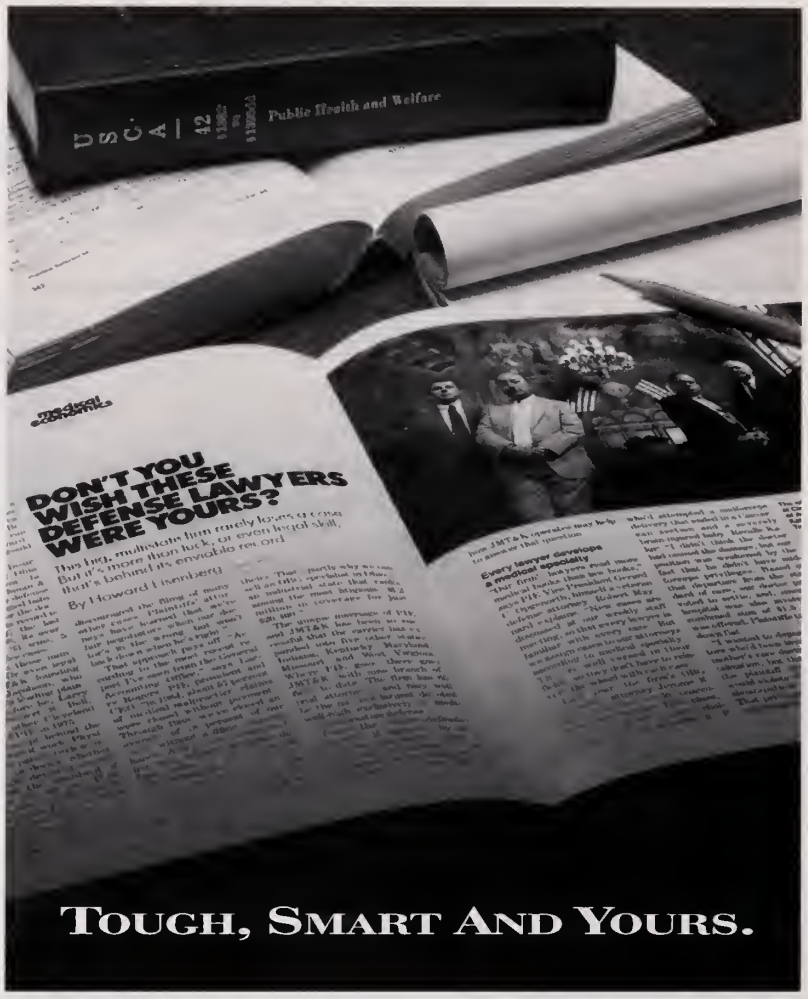
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Volume XXXVII, Number 7

Coding Workshop Schedule

MSMA & AMA Financing & Practice Services, Inc.
Fall 1996 CPT Coding for Doctors' Offices

CPT Coding, often frustrating in its nuances and technical detail, can and does have major impact on physician reimbursement. Beyond that, ICD-9 & CPT codes are the data sources needed for management decisions on pricing services and positioning the practice or clinic to remain fiscally healthy and viable in the future.

Workshop Objectives

Attendees will:
•Review the basics of the Current Procedural Terminology.
•Learn proper usage of E/M Codes.
•Discuss the meaning and appropriateness of modifiers.
•Become familiar with selected aspects or third party payer coding requirements.
•Discuss the physician's role in the coding process.
•Strengthen their understanding of coding's impact on reimbursement and data management.

Intended Audience
•Newer Coders (a minimum of 3 months experience is recommended.)
•Office Managers who have responsibility for overseeing the reimbursement function and need to understand the basics of coding.
•Physicians who want to better understand their role in the coding process.

A Medicare representative will be present to go over CPT changes in relation to Medicare criteria and to provide and update on any other pertinent matters that may effect your practice.

PLEASE BRING YOUR CPT MANUAL TO FULLY PARTICIPATE.

DATES & LOCATIONS:

Tuesday, Sept. 24th	Wednesday, Sept. 25th	Thursday, Sept. 26th
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REGISTRATION INFORMATION:
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ST. DOMINIC-JACKSON MEMORIAL HOSPITAL

HIV Infection Masquerading as Sjogren's Disease: A Clinical Dilemma

Stephen J. Nunenmacher, M.D.
Robert D. Holbert, M.D.
Edwin M. Davidson, M.D.

Introduction

Infection in the patient with the human immunodeficiency virus (HIV) is a major challenge to the primary care physician. The challenge can be related to diagnostic concerns such as how best to diagnose the unusual opportunistic infections associated with this pandemic. This article addresses one diagnostic challenge associated with HIV infection in that the virus, on presentation, can mimic Sjogren's Disease.

It was recognized several years ago by Itescu, et al, that HIV infection can be associated with lymphoid infiltration of various tissues including the parotid glands[1]. Salivary gland enlargement can also be seen in Sjogren's Disease, Lymphoma, and other infectious diseases, such as tuberculosis[2]. Our patient was initially diagnosed as having Sjogren's Disease based on his clinical presentation, as well as on histological data.

CASE HISTORY

B.W. is a 52 year old black male who has been a patient at the clinic for many years. His usual clinic visits were due to recurrent prostatitis and other minor illnesses. In February of 1988, he presented to the clinic with painless enlargement of the parotid glands. Laboratory evaluation was unrevealing. A course of antibiotics had no effect. Incisional biopsy was performed, and the tissue was interpreted as a lymphoepithelial lesion consistent with Sjogren's Disease. This diagnosis was confirmed by a pathology consultant at Tulane University in New Orleans, Louisiana. Further laboratory evaluation showed a polyclonal gammaglobulinemia.

The patient continued to be followed in the clinic for his usual afflictions. In March of 1992, he presented with an upper respiratory tract infection that was complicated by intractable hiccups. His infection was successfully treated, but the hiccups persisted, often causing vomiting and breathlessness. In August of 1992, he developed thrush. HIV testing was done, and he was positive on ELISA and Western Blot. His wife was tested at this time, and she was also infected with HIV. The risk factor in the social history was found to be heterosexual promiscuity on the part of the patient and his wife.

Since his diagnosis, he has had no opportunistic infections. He has had several episodes of severe bronchitis; however, bronchoscopic examination and ravage specimens revealed no unusual organisms. He was initially treated with AZT. When his T-4 count dropped, he

was switched to DDI. After an episode of pancreatitis, he was changed to D4T and currently has stable T-4 counts. The patient has had HLA typing and is DR5 negative and DR6 positive.

DISCUSSION

A number of studies have investigated whether an individual's genotype influences his immune response to HIV infection. Enlow, et al, described an increased frequency of HLA-DR5 in HIV patients with persistent lymphadenopathy[3]. Itescu, et al, reported a prevalence of HLA-DR5 and DR6 alleles in patients infected with HIV and exhibiting a diffuse infiltrative lymphocytosis syndrome (DILS)[4]. This syndrome is characterized by a CD-8 lymphocytosis and is noted to be similar to Sjogren's Syndrome particularly in the aspect of parotid gland enlargement. The DILS patient is also likely to exhibit a polyclonal hypergammaglobulinemia [5]. Itescu felt that the DILS represented a host response to HIV infection that is genetically determined. Another report, this by Gordon, et al, noted the relationship between chronic lymphadenopathy and a Sjogren's-like illness[6]. His patient also was noted to exhibit a polyclonal hypergammaglobulinemia.

CONCLUSION

In summary, we describe a patient with HIV infection who is mistakenly diagnosed as having Sjogren's Syndrome. He has been found to be HLA-DR5 negative and DR6 positive. His original parotid gland biopsies have been reviewed recently, and are felt to be consistent with a diffuse infiltrative lymphocytosis syndrome.

The availability of HLA typing will serve to expand our knowledge of how different people respond to infection with HIV. As a result, the unusual manifestation of common diseases may be explained as responses dictated by each patient's genotype. This case will hopefully bring to mind one more way that HIV infection can present, thus raising the index of suspicion for this disease.

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Stephen J. Nunenmacher, M.D. *- Dr. Nunenmacher is currently in practice in Internal Medicine in Gautier, MS, and is affiliated with the Biloxi Regional Medical Center.*

Robert D. Holbert, M.D. *- Dr. Holbert is currently practicing Internal Medicine in Gautier, MS, and is affiliated with the Biloxi Regional Medical Center.*

Edwin M. Davidson, M.D. *- Dr. Davidson practices Hematology/Oncology in Gulfport, MS, and is affiliated with Gulfport Memorial Hospital.*

Requests for reprints may be addressed to: Stephen J. Nunenmacher, M.D.
P. O. Box 715
Gautier, MS 39553.

NATIONAL HIV TELEPHONE CONSULTATION SERVICE

The National HIV Telephone Consultation Service, "Warmline" (800-933-3413) based at San Francisco General Hospital provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists, and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 am and 5:00 pm PST. A twenty-four hour voice mail system is available at other times.

The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers, and the American Academy of Family Physicians.

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Heart Failure Evaluation and Treatment in Mississippi: Results from a Survey of the Mississippi Foundation for Medical Care

John B. O'Connell, M.D.
Alton B. Cobb, M.D.
and the Heart Failure Study Group

Introduction

Mississippi ranks third in the United States for deaths due to cardiovascular diseases with 367.3 deaths/100,000 population in 1989.[1] Furthermore, during 1993 45% of all deaths in Mississippi were due to cardiovascular diseases accounting for 11,850 fatalities.[2] In 16 (20%) of the counties in Mississippi, cardiovascular diseases accounted for more deaths than all other causes combined (> 50%).

In 1993, there were 3,571 people who died of heart failure (HF) in Mississippi representing almost one third of the cardiovascular deaths and 14% of all deaths.[3] To place this value in perspective, if the heart failure deaths in Mississippi were predicted based on the U.S. data, Mississippi mortality is 20% higher than the 2,986 predicted HF deaths. The high mortality from HF may be accounted for by the fact that more than 70% of HF in the U.S. is the result of poorly-controlled hypertension and Mississippi has one of the highest frequencies of hypertension at 41 percent among Blacks and 30 percent among Whites. It is estimated that more than 400,000 people in Mississippi have either undiagnosed or untreated hypertension. Mississippi also ranks 13th in death rate due to diabetes and the second in percentage of overweight adults.[1] Based on 1993 Medicare data Mississippi has more than 9,000 patients with congestive heart failure accounting for in excess of 12,000 hospitalizations. Medicare (DRG 127) alone accounted for more than 10,000 of those hospitalizations representing 7.1% of all hospitalizations in the state. The average length of stay was 7.1 days and the readmission rate 21.7% within 30 days of discharge. The payment to DRG 127 in 1993 was greater than $70 million, representing only a fraction of the total charges based on Medicare DRG reimbursement policy. Assuming that Medicare accounts for 80.3% of all heart failure patients based on national data, total Mississippi inpatient charges may exceed $120 million with outpatient charges exceeding $32 million and total expenditure exceeding $150 million.[4]

Treatment options for HF have broadened significantly in the last decade.[5] However, there has been a delay in application of these therapies. Specifically, angiotensin converting enzyme (ACE) inhibitors have been demonstrated to unequivocally prolong life in patients with symptomatic HF and reduce morbidity (development of HF or hospitalization) in those with asymptomatic LV dysfunction. Most of the literature is targeted to the cardiologist yet less than 25% of patients

are managed by cardiologists; the treatment of HF is appropriately allocated to the primary care physician. The National Disease and Therapeutic Index analyzed the drugs used in the chronic treatment of HF and reported 72% of patients were receiving diuretics, 51% digitalis glycosides and only 24% the indicated ACE inhibitors. During the evaluation phase of the Studies of Left Ventricular Dysfunction (SOLVD), 5,999 seriously ill patients (74% hospitalized) were screened for enrollment and only 32% were receiving ACE inhibitors.[6] When administration of ACE inhibitors was analyzed based on initial prescription, less than 20% of patients were prescribed an ACE inhibitor and the difference in frequency of ACE inhibitor administration between cardiologists and primary care physicians was negligible.[7]

Therefore, effective therapy has been identified but the application of that therapy has been delayed. With the ever increasing demands for a cost-efficient, effective health care delivery system, the federal Agency for Health Care Policy and Research (AHCPR) opted to target their eleventh clinical practice guideline to the evaluation and treatment of heart failure, stressing several very important points.[8] The first step in managing the ambulatory patient with HF is the estimate of left ventricular ejection fraction (LVEF) by echocardiography or radionuclide ventriculography (MUGA scan or gated heart scan). If systolic dysfunction is identified, ACE inhibitors are indicated regardless of severity of symptoms. Asymptomatic patients with a reduced LVEF (below 35-40%) should also receive an ACE inhibitor which is likely to reduce the chance of development of clinical HF and subsequent hospitalization.

The unexpectedly high mortality for HF in Mississippi prompted the development of a survey to ascertain whether patients hospitalized for HF undergo the accepted diagnostic evaluation (measurement of LVEF) and receive ACE inhibition for treatment. The project initiated by the Mississippi Foundation for Medical Care (MFMC) was designed to improve outcomes of patients with HF by educating providers on the importance of early objective evaluation of left ventricular function and effectiveness of ACE inhibitors. The purpose of this report is to describe the results of a preliminary survey of HF management in Mississippi hospitals.

Materials and Methods

The initial survey was a component of the Health Care Quality Improvement Program of the MFMC. A questionnaire was designed to capture information regarding demographics, diagnostic evaluation and treatment of patients discharged from Mississippi hospitals with the principle diagnosis of "Heart Failure" (DRG 127). Retrospective chart reviews were completed by the field staff of the MFMC and documentation of measurement and quantitation of LVEF was recorded. Similarly, documentation of current or previous administration of ACE inhibitors was sought. Cases were analyzed with regional balance and stratified by hospital size ($\leq$ 100 beds vs $\geq$ 100 beds). Other variables included attending physician specialty and comorbid conditions. Group percentage differences were evaluated by chi-square analysis. A p value $\leq$.05 was considered statistically significant.

Results

The study population consisted of a random sample of Medicare beneficiaries hospitalized for heart failure from January 1, 1994 through June 30, 1994. The mean age of the 672 patients in the sample was 76 years and the average length of stay was 6.65 days. Five were excluded because the patient was transferred to another hospital where care was continued or the patient left the hospital against medical advice. Additionally, five patients were excluded because of a history of absolute contraindications to ACE inhibitors. The remaining 662 patient records served as the source of this report; 300 were from hospitals $\leq$100 beds and 362 from hospitals $\geq$ 100 beds (Table I).

Table I

Study Population
n = 662

• Gender	male 38% / female 62%
• Race	white 62% / black 37%
• Attending Physician	general internists and family physicians 83%
• Comorbid Conditions	Hypertension 59% Diabetes mellitus 34%
• Hospital Size	< 100 beds 35% > 100 beds 65%

Males represented 39% of the population and females 61%. Sixty-two percent were white and 37% were black. General internists and family physicians were the most common attending physicians accounting for 83% of the hospitalizations and cardiologists were the attending physician in only 6%. The most common comorbid conditions included hypertension (59%) and diabetes mellitus (34%).

Left ventricular function was documented in 318 patients (48%) and EF recorded in 218; 69% of those in whom the diagnostic test was performed. Surprisingly, left ventricular ngiography represented the most common

measure of LVEF (77%). Echocardiography (19%) and radionuclide ventriculography (4%) accounted for a less than expected proportion. Left ventricular ejection fraction was ≤.35 in 46% of those in whom it was documented and ≤.45 in 42%.

Patients commonly received ACE inhibitors and 57% of all patients were discharged on those medications including 81% of those with LVEF ≤ 0.35 (Table II).

Table II

Relationship of Discharge on Angiotensin Converting Enzyme (ACE) Inhibitor to Measured Ejection Fraction

Ejection Fraction	n	ACE Inhibitor Use
all patients	662	57%
≤ 0.35	101	81%
≥ 0.45	92	45%
not documented	344	51%

However, 51% of those without documented LVEF and 45% of those with LVEF ≥0.45 were also discharged on ACE inhibitors. The most commonly administered ACE inhibitors included captopril (54%), enalapril (28%) and lisinopril (9%). In hospitals with ≤100 beds LVEF was documented less often (25% vs 67%) yet ACE inhibitor use was comparable (56% vs 59%).

Although patients seen by cardiologists were more likely to have LVEF assessed (80% vs 45%, p≤0.001), no difference in discharge on ACE inhibitors by attending physician could be detected (61% vs 58%). Patients admitted to hospitals with ≥ 100 beds were 6.72 times more likely to have an evaluation of LVEF than hospitals with ≤ 100 beds. Patients discharged to nursing homes were .39 times less likely to receive an evaluation than a patient discharged to home. Patients discharged to home health were .64 times less likely to receive an evaluation than patients discharged home. Patients with diabetes as a comorbid condition were .63 times less likely to receive an evaluation than patients without diabetes.

Further analysis was performed excluding 19 dialysis patients and gender difference analyzed, women were less likely to have LVEF assessed (p=0.034) but there was no difference in frequency of application of ACE inhibitors (Table III). Women were more likely to be hypertensive than males (p=0.040). Similarly, analysis of racial differences noted that whites and non-whites had no difference in the likelihood of assessment of LVEF but non-whites were more likely to be receiving ACE inhibitors (p=0.026), more likely to be hypertensive (p≤0.001), and more likely to be diabetic (p=0.015) (Table IV).

Table III

Gender Differences with 19 Dialysis Patients Excluded (n=643)

	Males	Females	p value
n	247 (38%)	396 (62%)	
Assessed LVEF	131 (53%)	176 (44%)	0.034
ACE Inhibitors	154 (62%)	223 (56%)	0.131
Comorbid Conditions			
Hypertension	130 (53%)	241 (61%)	0.04
Diabetes Mellitus	81 (33%)	138 (35%)	NS

LVEF = left ventricular ejection fraction; ACE = angiotensin converting enzyme

NS = Not statistically significant at .05 level

Table IV

Racial Differences with 19 Dialysis Patients Excluded (n=643)

	White	Non-White*	p value
n	400 (62%)	243 (38%)	
Assessed LVEF	192 (48%)	115 (47%)	NS
ACE Inhibitors	221 (55%)	156 (64%)	0.026
Comorbid Conditions			
Hypertension	203 (51%)	168 (69%)	<0.001
Diabetes Mellitus	122 (30%)	97 (40%)	0.015

* All except 100 Black

LVEF = left ventricular ejection fraction; ACE = angiotensin converting enzyme

NS = Not statistically significant at .05 level

Discussion

Efficient health care delivery is becoming increasingly important in this era of cost consciousness. Although effective new treatments may be introduced to manage serious illnesses like heart failure, the effect on health care delivery can only be measured when the therapy is broadly applied to the appropriate population. National analyses suggest that in the case of heart failure the unequivocally effective ACE inhibitors have not been administered to even one-half of the patients in whom they are indicated.[6,7] There is little doubt that enhancing administration of this indicated therapy will save lives and maintain productivity. Furthermore, the cost savings for an illness accounting for more than 5% of the health care dollar may be appreciable.[4] This survey was designed to identify a baseline from which targeted intensive education and subsequent quality improvement could directly benefit those afflicted in Mississippi.

It was gratifying to note the high prevalence of use of ACE inhibitors in patients discharged with the diagnosis of heart failure. Although this survey did not encompass the overall population of heart failure patients and

was restricted only to those hospitalized where Medicare data were available, it is unlikely that patients in Mississippi receive ACE inhibitors at any lower frequency than patients from other states. ACE inhibitor use is independent of the measurement of LVEF, hospital size, gender, or attending physician. ACE inhibitors are more commonly used in non-whites than whites. However, the comorbid conditions, hypertension and diabetes, which are at higher frequency in the non-white population may solely account for the greater frequency of ACE inhibitor use.

The most disturbing component of this survey was the lack of careful documentation of LVEF; less than half of the patients had evidence of a measured LVEF and only 69% of those in whom it was measured was the number actually recorded. Analyses of application of ACE inhibitor use for heart failure must be contingent upon abnormal systolic function. It is unclear whether ACE inhibitors benefit patients with HF and normal systolic function which comprised an appreciable proportion of our study population, unless the indications for ACE inhibitors are other comorbid conditions. In our survey hypertension and diabetes both of which may be independent indications for ACE inhibitor may explain the unusually high frequency of ACE inhibitor use in patients with normal LVEF. Additionally, since LVEF was measured most commonly by left ventricular angiography, it is highly likely that the measurement may have been remote to the current hospitalization for heart failure, since hospitals with $\leq$100 beds ordinarily do not have the capability of LV angiography. Consequently, this measurement may not reflect the current state of left ventricular systolic function. Although cardiologists were not more likely to administer ACE inhibitors than non-cardiologists, a higher frequency of measurement of LVEF was observed when the patient was under the care of a cardiologist. The more common measurement of LVEF in patients managed by cardiologists may be a reflection of the severity of illness which prompts the referral from the primary care physician. Unfortunately, severity of illness was not quantitated in this survey. Noninvasive measurement of LVEF may also reflect easy accessibility and/or greater familiarity with the assessments of LVEF function.

This analysis has major limitations in that the data are contingent upon a retrospective chart review. It is highly likely that several of the patients did in fact have LVEF measured but it was simply not recorded in the chart and inaccessible to the surveyor. The specific indications for ACE inhibitors were not assessed and the placement of patients on ACE inhibitors for heart failure may have been coincidence because of comorbid conditions rather than specifically indicated therapy. This survey could not explore the global practice standards since it was biased towards hospitalized patients funded under Medicare. It is estimated that at least 20% of the heart failure population is not funded by Medicare. Many patients with heart failure do not have symptoms of sufficient severity to warrant hospitalization and would not be included as part of this survey. This is particularly relevant since ACE inhibition is clearly indicated even in patients with asymptomatic left ventricular dysfunction who would have no indication for hospitalization.[8,9]

This survey may be used as a point of discussion for developing quality improvement programs and practice standards throughout the hospitals and ambulatory centers in Mississippi. It is our purpose to reanalyze this problem with a similar survey after quality improvement measurements have been implemented. If in fact the number of patients receiving ACE inhibitors rise to twice the national average the net savings over a three year period would likely exceed $10 million by reduction in hospitalizations. It is our hope that the quality improvement programs that evolve from study of these data will have a favorable impact on the cost efficiency and delivery of health care for heart failure patients in Mississippi. ❑

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This survey was conducted by the Department of Medicine, University of Mississippi Medical Center and Mississippi Foundation for Medical Care.

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Survey Shows Mississippi Gulf Coast Ranks Fourth in Top Employment Markets For Physicians

Irving, TX — Managed care is reducing the need for medical specialists and soon tens of thousands of physicians will be underemployed or out of work. So, at least, is the commonly accepted wisdom of academics and other health care manpower experts.

Not so fast, say physician recruitment consultants at Merritt, Hawkins & Associates, a national medical staffing firm headquartered in Irving, Texas. The first annual survey of the top ten employment markets for physicians indicates that over 70 percent of the nation's hospitals are recruiting physicians as are over 60 percent of larger medical group practices.

The survey also identifies the top ten employment markets for physicians -areas where physician recruitment in a variety of medical specialties is particularly aggressive. These markets, in alphabetical order, include:

* Eastern Washington State
* Evansville, Indiana
* Fargo, North Dakota
* **Mississippi Gulf Coast**
* North Central Florida/Panhandle
* Northwest Arkansas
* Quad Cities, Iowa
* Springfield, Missouri
* Southern California
* West Texas

According to Merritt, Hawkins & Associates' president, James Merritt, the survey provides a "snapshot at street level" of the current physician supply and demand picture in the United States.

"What's clear is that while managed care is driving physicians out of some markets, jobs are still available in other markets traditionally underserved by physicians," Merritt states. "The problem is still one of maldistribution rather than oversupply."

HELP WANTED

Merritt points to several of the top ten markets as examples of national physician staffing trends. Fargo, North Dakota, he observes, is located in a rural state with a traditionally low physician-to-population ratio. A growing college community with four hospitals, Fargo needs primary care physicians, (e.g., family practitioners, pediatricians, and internists), orthopedic surgeons, cardiologists and neurosurgeons.

Springfield, Missouri is an example of a mid-sized city undergoing health care realignment due to the recent arrival and expansion of managed care, Merritt says. The three hospitals in the community are vying for managed care contracts, and consequently need primary care physicians as well as a complement of specialists such as obstetrician/gynecologists and general surgeons.

Merritt cites Southern California as a major urban area with a high rate of managed care hat nevertheless needs additional physicians. Though some physicians are leaving Los Angeles due to the downward financial pressure imposed by managed care, a variety of doctors are needed in the growing outlying areas of the city. Merritt points to a search his firm currently is conducting for an obstetrician/gynecologist in Orange County as an instance of physician demand in a popular urban area. He also observes that physicians who are bilingual in English and Spanish are in considerable demand throughout ethnically diverse Southern California.

WHO'S AFRAID OF THE BIG, BAD GLUT?

Merritt concedes that the majority of hospitals and medical groups recruiting physicians are seeking primary care practitioners. However, he does not agree with some experts who believe that tens of thousands of medical specialists will be driven out of medicine by managed care.

"Thirty percent of physicians in the U.S. are 55 years old or older," he states. "Many of these physicians can afford to take early retirement, and already are doing so. New technologies, the graying of the patient population, and patient demand will ensure the need for younger specialists."

What will change, Merritt believes, is the way physicians go about seeking practices. They may no longer be able to practice within fifty miles of where they were raised or where they were trained. Instead, they will have to do what other professionals long have done — go where job opportunities take them.

"Physicians will need to add a career mindset to their scientific mindset," Merritt states. "That means an aggressive job search and a strong consumer orientation."

THE MISSISSIPPI GULF COAST
Picayune, Gulfport, Biloxi, Pascagoula, Bay St. Louis

Number of hospitals.....11
Number recruiting.....11
Percent recruiting.....100
Number of medical groups of 5 or more physicians....6
Number recruiting.....4
Percent recruiting.....60

Market Conditions:

Need for physicians driven by anticipated growth of managed care and economic development extending eastward from New Orleans along Mississippi coast. Coastal lifestyle, low cost of living, and strong economic opportunities create favorable practice conditions.

Physicians needed:

Family practitioners, pediatricians, internists, cardiologists, orthopedic surgeons, otolaryngologists.

TRENDS AND OBSERVATIONS:

Parts I and II of the report indicate a continued strong demand for physician services in a variety of specialties nationwide, with over 70% of hospitals and 60% of larger medical groups seeking physicians.

In many cases, demand is being driven by the growing prevalence of managed care, which puts a premium on primary care physicians. In other cases, economic and population growth are driving demand.

Based on the results of this survey, there appears to be little evidence of the "physician glut" predicted by some health care experts. Rather, there continues to be a maldistribution of physicians, particularly surgical and diagnostic specialists, who are concentrated in large urban areas. Some of these physicians may be compelled to relocate to smaller markets as managed care expands.

Primary care physicians, by contrast, are in significant demand in the majority of both large and small markets nationally.❑

METHODOLOGY

The survey was based on interviews conducted by Merritt, Hawkins & Associates' marketing consultants with medical staffing decision makers at over 4,500 hospitals and over 2,500 medical groups of five physicians or more. The telephone survey was conducted during the six month period from October 1, 1995 to March 31, 1996.

The Top Ten Employment Markets for Physicians were selected by Merritt, Hawkins & Associates' marketing consultants based on their analysis of the recruitment history, current medical staffing trends, and medical practice conditions in their respective territories.

Criteria for selection into the Top Ten included a clearly demonstrable need for physicians, the availability of relatively favorable practice conditions, and favorable prospects for future practice growth and stability. The Top Ten therefore does not include inner city areas, virtually all of which have an acute need for physicians, Indian reservations, and other traditionally underserved areas where practice conditions may be problematic.

The survey is available free to interested parties and may be obtained by calling Merritt, Hawkins & Associates at (800) 876-0500. The survey also is available through the firm's Internet address: http://www.practicenet.com.

Sources: Hospital Statistics, American Medical Association.

Note: Figures given in the "Number of medical groups" category in Part I for specific geographic areas are based on the number of medical groups of five physicians or more in those areas that are Medical Group Management Association (MGMA) members only. The total number of medical groups of five physicians or more in these areas (e.g., both MGMA members and non-members) will be higher. These figures, however, are not available.

UR and Percent Requirements

BACKGROUND

In 1990, MSMA sponsored and the Mississippi Legislature enacted laws governing the performance of "utilization review" for the purpose of determining whether medical services are reimbursable under a health insurance policy or other health benefits plan. This includes "pre-certification" that is generally required prior to being admitted, as either an inpatient or outpatient, to a hospital. These laws require that any entity performing "utilization review" be certified annually by the State Department of Health and comply with regulations governing the conduct of the review. Since practically every health benefits policy or plan involves the prospective, concurrent and/or retrospective review of medical services, the physician and his/her staff should be aware of their rights and the requirements for performing UR in Mississippi.

KEY ELEMENTS OF LAW AND REGULATIONS

Both state law and the Department of Health's regulations governing the conduct of utilization review contain several requirements that are important to you:

• A third party payer may not decline coverage of a service, for reasons of lack of medical necessity, provided to an insured person in Mississippi unless that payor's review program has been certified by the Department of Health.

• When someone representing the entity conducting the review ("review entity") contacts you to obtain information or discuss a patient's case, that individual must provide you with the company's state certification number, his/her name and professional qualifications.

• When conducting prospective and concurrent review, the review entity should only request the information necessary to certify the admission, procedure and/or length of stay. Copies of medical records should not routinely be requested on all patients reviewed.

• Every certified review entity must provide toll-free access to its staff from 9:00 a.m. to 5:00 p.m. central time on official business days.

• If a review entity has refused to certify or authorize a covered service the patient's physician must be provided with the clinical basis for that determination if requested.

• A physician must concur in any decision by the review entity to decline coverage of a service. This physician must also be reasonably available by phone to discuss with the attending physician the clinical reasons for denying coverage of the service.

• If the attending physician chooses to appeal the review entity's denial of coverage, he may request that the case be reviewed by a physician in the particular specialty that typically manages the condition or performs the service in question. The review entity is obligated to provide such specialty review and permit the attending physician to discuss the case with the reviewing physician on appeal.

• If the attending physician certifies in writing to an insurer or health plan within 72 hours of an admission that the patient was in need of immediate hospitalization, then this shall be considered as "prima facie" evidence of the medical necessity of the admission.

Physicians should report any violations of these requirements by an insurance company, health benefit plan or review entity to the: **Bureau of Licensure and Certification, Mississippi State Department of Health**
P.O. Box 1700, Jackson, MS 39215-1700
Telephone 960-7400

PROTECTING YOURSELF FROM LIABILITY FOR REVIEW DECISIONS

Although the liability of third party payors for patient injuries related to their review activities is somewhat unsettled, some courts have held that payors may be liable for any harm that results from their decisions affecting the coverage of services when those decisions involve determinations of medical necessity and appropriateness. Courts have also held that the attending physician in such cases may share that liability if he fails to fully exhaust any rights of appeal on behalf the patient in challenging review decisions. The physician must be ever vigilant in monitoring the decisions of payors and review entities and act as an advocate for the patient whenever he disagrees with those decisions. This means that the physician should fully exhaust all of the appeal rights enumerated above whenever he does not fully concur with a review entity's decision. After appealing an unfavorable decision, if the payor still declines coverage the patient should ultimately decide whether to have the treatment at his or her own personal expense after the physician has fully explained all of the options, alternatives and likely outcome. Every step of the appeals process that is undertaken, as well as every discussion with the patient related to the appeal and the need for the treatment, should be thoroughly documented in the patient's record. ❑

Medical Hall of Fame Names Mississippi Physicians In New Book

ST. LOUIS, MO - Four famous physicians from MISSISSIPPI are among those featured in a new book entitled, "An All American Medical Hall of Fame" ($24.95).

The physicians included from Mississippi are:

Henry Boswell, M.D.
Thomas Melville Dye, M.D.
Billy Sylvester Guyton, M.D.
J. Felix Underwood. M.D.

The book is the work of a senior medical executive, Hollister S. Smith of Chesterfield, Missouri. He has spent his spare time over a 17-year period collecting the data and pictures. The book is a tribute to a great number of men and women from every state and thirty of the major medical specialties from the last two centuries in America. The nominations to the "Hall" were painstakingly done through the American Association of Medical Society Executives by appointed medical historians and state medical committees. The "Hall" members selected were not to be living at the present time. They were judged to have made significant contributions to many advances in the art and science of medicine in their particular areas of expertise.

"As a member of the American Association of Medical Society Executives since 1955 and editor for 12 years of its monthly publication, The Medical Executive, I had the privilege of working with physicians," said Smith. "Through the remarkable dedication and passion of the medical profession, its advances in research on medical treatment and cures for many life threatening illnesses such as polio, tuberculosis and even some forms of cancer, have been materially reduced. It was an honor to document the achievements of this collective group of physicians and to give them a much deserved place of honor in this medical hall of fame anthology," Smith said.

Also included in this 160-page volume are other recipients or medical awards. The author included Americans who have received the Nobel Prizes in medicine and physiology; all the presidents of the American Medical Association from 1847-1995; physicians cited in eight separate categories of distinction by the AMA and the fifteen physicians honored by the United States Postal Service on U.S. Stamps.

With 325 pictures and biographical sketches of four physicians from every state in the U.S. as well as Canada and Peru, the book acknowledges the caring and dedication of some of the most distinguished members of the medical profession from 1796-1996.

Copies of An All-American Medical Hall of Fame can be obtained by mailing a check or money order made payable to An All-American Medical Hall of Fame in the amount of $24.95 per copy to: 605 Thunderbird Court, Chesterfield, MO 63017. Price includes shipping and handling.❑

Mississippi Physicians Rank Top on List of States Taking Serious Disciplinary Action Against Physicians

For five years, a nonpartisan consumer group has put Mississippi at the top of the list of states that take serious disciplinary action against physicians.

Such action includes suspending or revoking a medical license for example, sexual abuse of patients, fraud or improper prescribing of drugs.

Dr. Rick Peden of Gulfport, president of the state Board of Medical Licensure, credits a conscientious staff, top-notch investigators and cooperative pharmacists with much of the work that earned the state's highest rating.

Although, it's true that an alert pharmacist is in a position to spot excessive or improper prescriptions. It's also true that reports of offenses are of little use without a disciplinary board committed to the highest medical and ethical standards.

Clearly, the physicians who serve on Mississippi's board have the backbone to uphold standards—not an easy task one's professional peers.

A high ranking doesn't indicate more bad doctors; it indicates low tolerance for unacceptable performance. "It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than instates like Georgia, Iowa, West Virginia, Alaska and Mississippi, all in the top 10 in 1995," the Public Citizen study said.

Dr. Sidney Wolfe, author of the study, said states with the best rankings generally have boards with "strong, well-organized, hard-working" leaders, like Mississippi.❑

WHEN YOU NEED TO BE SEVERAL PLACES AT ONCE, ISN'T IT A RELIEF TO KNOW YOUR BANK WILL BE THERE, TOO?

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372N06

St. Dominic Health Services to Build Residential Alzheimer's Facility

St. Dominic Health Services' (SDHS) announces groundbreaking for a new 36-room residential Alzheimer's facility, Campbell Cove, located on SDHS's St. Catherine's Retirement Village property in Madison County, Mississippi.

Campbell Cove will provide an alternative to the traditional nursing facility placement. It will be a small-scale freestanding, residentially-oriented, personal care setting with minimal institutional characteristics.

A warm, homelike atmosphere will decrease distraction and confusion. The 36 residents' rooms will be arranged in clusters of 12 and these 12 residents will take their meals together in their own special dining area. This will give a more family atmosphere to mealtimes. It also enables the residents to feel more at home in their own secure environment to which they are accustomed.

A rich social life, interactions and relationships among residents, staff, volunteers and family visitors will be an important part of life at Campbell Cove.

Campbell Cove's mission will be to enable residents to function at their highest possible level, enhance their quality of life and slow behavioral deterioration.

Construction is expected to be completed by mid-1997.

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You are invited to participate. Any medical staff of a hospital, integrated delivery system, or health care plan may designate an OMSS representative, who must be an AMA member with active medical privileges.

If you are interested in attending an upcoming meeting and/or designating an AMA OMSS representative call **800 AMA-3211** and ask for the AMA Department of Organized Medical Staff Services.

We cannot begin to confront the unique challenges facing us without you. Call **800 AMA-3211** today.

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Fred L. McMillan, M.D.

The President's Page

Unity

One of my concerns about how the practice of medicine will be in the future has to do with unity. We must have professional unity on a community level, state level, and national level. There must also be unity on an inter-specialty level. The potential for fragmentation has never been greater than with health care being paid for by a third party who is pushing to limit these monies.

The gains one physician receives is another's loss. In addition, we all lose some as the forces in business and government try to usurp our role in managing our patient's care. These new medical managers see the opportunity to make large sums of money out of the medical industry without adding to the patients' welfare. They want to manage our care of the patient without the compassion, the involvement, the experience, and the knowledge of physicians.

Competition is inevitable; however, we must assure that we maintain the same ethical standards now and in the future as we have in the past. If not, what happens to our profession - what happens to our organization - what happens to our patients?

Each physician, by his own actions, must make sure others keep the good of the patient first. The family physicians who practiced in my hometown of Carthage, and were the role models that inspired me to be a physician, still set the standard for me 30 years later as I recall how they always put the patient first. My father owned a drug store and as a result we had a close relationship with them. Hearing them laugh and talk, about driving out in the country late at night on muddy slick roads to attend to a patient knowing that there was only minimal if any payment to be received, brings back into focus why we went into medicine in the first place...

Not to simply remove a gallbladder but to restore that patient's health so he or she could go back to work and their families and give us a thank you.

Not to make ourselves rich but to be able to give care to that patient unable to afford that care.

Not for fame and glory but to gain the respect of our community and to accept our responsibility as leaders in that community.

Remembering why we went into medicine in the first place and staying with those same goals makes the practice of medicine fun and rewarding. It also provides the unity we must have. Unity is essential in overcoming our competitiveness and short-term individual goals that can prevent physicians from regaining the leadership role in the delivery of health care.

What do we need to do to regain this central role? My thought on that next month.

Fred



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AIR FORCE

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVII, NUMBER 7
JULY 1996

WHAT DO THEY REALLY THINK ABOUT US?

Several days ago a medical student ask if I had seen the article "HEALTH BILL WOULD SHACKLE DOCTORS - LITERALLY" (Wall Street Journal, May 30, 1996) by Dr. Jane M. Orient, and what were my feelings regarding "what those in Washington thought about practicing physicians"? The next question was, "Should I continue to study medicine with all the drastic changes now taking place?".

I had thoroughly reviewed the article referred to and was very disappointed by what was said. The Kasselbaum-Kennedy health care bill is a serious slap in the face to the majority of physicians in this country. I would be the first to acknowledge that our ranks are not pure. We do have some charlatans that rank equally with the old medicine man who traveled the country by horse and wagon. We do have unnecessary procedures being done, some outrageous fees charged, and impersonal care rendered, but I also believe these represent a small minority of medicine and that there are ample laws, rules and regulations to control these problems; they only have to be applied. If it is thought absolutely necessary to make changes then why are we singled out of the health care force with such restrictive and vindictive laws? Why are we not given the same rights as others in the health care chain? The third party agencies do not operate under such restrictions and threats.

In answering the first question I must say that those in the House of Representatives and the Senate, who voted overwhelmingly in favor of this legislation, were not thinking about medicine; good, bad or indifferent. Very few took any notice of what was in the bill. Reportedly one Senate staff member said "the senator didn't even care what was in the bill, as long as it passed". I was truly depressed to know that our own members of Congress were in the group supporting the Kasselbaum Kennedy health care bill.

What do they really think about us? Who knows?

The second question is also difficult to answer. With bills being passed without review there is no magic ball to predict what will come out of Washington which could forever change medicine as we know it. While many of my colleagues say they would encourage their children, and others, to avoid medicine as a career I do not share that feeling. Medicine as a profession will not be done away with. Sure, there will be changes in the way medicine is delivered but who will be more prepared and capable of facing these changes that the young physicians of this country. Unencumbered by past history and practice experiences they will be more capable adapting to change. If one is interested in working with people, intellectual challenge, hard work, research, personal satisfaction and a piece of the action in helping shape the future of medicine then go for it; if you don't, who will?

Myron Lockey, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

REPORTABLE DISEASES - 1996

MISSISSIPPI STATE DEPARTMENT OF HEALTH
(Mississippi Code of 1972 as Amended)

This listing of diseases reportable under the requirements of the State Board of Health is made available for quick reference and posting to assist practitioners and institutions in complying with the rules and regulations. More detailed information is contained in the Rules and Regulations Governing Reportable Diseases, copies of which are available upon request from the Division of Epidemiology, Mississippi State Department of Health, P.O. Box 1700, Jackson, MS 39215-1700.

Class 1 Diseases: Telephone Report Within 48 Hours

Statewide: 1 -800-556-0003 *
Jackson Calling Area: 960-7725*

Class 2 Diseases: Mail or Telephone Report Within One Week

Mail to: Division of Epidemiology
State Department of Health
P. O. Box 1700
Jackson, MS 39215-1700
or call: 1-800-556-0003 (960-7725 in Jackson calling area)

Case Report Cards for written reports are available through the local health department or the Division of Epidemiology. All reports made shall include, unless otherwise specified, the patient's name, address, age, race, sex, the disease or condition, the date of onset, method of diagnosis, and the person or institution reporting.

Class 1 Diseases - Immediate Report:

- AIDS
- Anthrax (in man)
- Botulism
- Chancroid
- Cholera
- Dengue
- Diphtheria
- Encephalitis
- Escherichia coli 0157:H7
- Hepatitis A
- HIV infection
- Measles
- Meningitisis or other Invasive Disease
  - Due to:*Neisseria meningitidis*
  - *Haemophilus influenzae-b*
- Pertussis
- Plague
- Poliomyelitis
- Rabies (human or animal)
- Siphilis
- Trichinosis
- Tuberculosis (active)
- Typhoid
- Yellow Fever

Any Case of Rare or Exotic Communicable Disease

Any Suspected Outbreak (including foodborne outbreaks)

Class 2 Diseases - Report Within One Week:

- Actinomycosis
- Acute Rheumatic Fever
- Amebiasis
- Ascariasis
- Blastomycosis
- Brucellosis
- Campylobacteriosis (Not *Helicobacter pylori)*
- Chlamydial Infection
- Coccidioidomycosis
- Congenital Rubella Syndrome
- Cryptococcosis
- Giardiasis
- Gonococcal Infection
- Hansen's Disease (Leprosy)
- Hepatitis B
- Hepatitis non-A, non-B (Hepatitis C)
- Hepatitis, unspecified
- Histoplasmosis
- Hookworm
- Hydatidosis
- Legionellosis
- Leptospirosis
- Lyme Borreliosis
- Malaria
- Meningitis (other than Meningococcal or *H. influenzae)*
- Mumps
- Nontuberculous Mycobacterial Infection
- Poisoning**
  (Including Elevated Blood Lead Levels)
- Psittacosis
- Q Fever
- Relapsing Fever
- Reye Syndrome
- Rocky Mountain Spotted Fever
- Salmonellosis
- Shigellosis
- Spinal Cord Injury
- Taeniasis
- Tetanus
- Toxoplasmosis
- Tularemia
- Typhus Fever
- Vibrio Infection (other than Cholera)
- Viral Encephalitis in Horses

***The Division of Epidemiology (960-7725) is available for consultation regarding any aspect of reportable diseases. For after hours, night and weekend assistance or for emergency case reports, call 960-7400, 24 hours a day, 365 days a year.**

****Reportable through the University of Mississippi Medical Center Regional Poison Control Center**

Mississippi State Department of Health Revised 3-29-96 Division of Epidemiology

Happy 25th Anniversary, MFC

July 6, 1971, the date on the charter of incorporation of the Mississippi Foundation for Medical Care, Inc., makes July 1996 a special time for the Foundation.

What enhances the 25th year, making it more worthy of special attention than say, the 15th, 18th or 20th year? Maybe it's the "Silver" designation or just the fact that two decades plus five years suggests a credible historical perspective.

Some not-so-subtle hints over the past several months have indicated that this is a very special year for the Foundation for Medical Care. A 25-year anniversary logo has highlighted several items, including the annual session report released at the State Medical Association meeting May 2, as well as the FMC exhibit which was displayed in the Convention exhibit hall May 2 and 3. Special stationery with the 25th logo has also been designed to share the news.

Twenty-five years ago, John Bell Williams was governor, and Heber Ladner served as the secretary of state; both their signatures are on the charter.

Physicians signing the charter were J. T. Davis, M.D., of Corinth, who served as medical director; Everett Crawford, M. D., Tylertown, and James O. Gilmore, M. D., Oxford.

Housed at 735 Riverside Drive in Jackson, the Foundation was described as nonprofit and a civic improvement corporation, governed by a board of directors, with each member having voting privileges.

Reading the charter these 25 years later brings no surprises. Purposes for the Foundation included:

·To promote, develop, encourage, and assist in the distribution of quality medical care to the general public in Mississippi at a reasonable cost to the patient and provider and in accordance with proper medical and ethical standards;

·To study and promote improved methods and facilities for health care and the improvement and protection of the public health;

·To study, implement, and assist in the administration of means of financing health care, acting in conjunction with medical societies or associations, patients, hospitals, nursing homes, and other health care facilities, and the insurance industry, hospital service corporations, voluntary prepayment plans, various branches of government, representatives of management and labor and other interested persons, organizations and corporations;

·To promote the art and science of medicine and to foster medical and professional education; and

·To disseminate information to the general public concerning medical science and quality, ethical medical care.

We can't state the purpose any better today. The Foundation, working under various contracts over the 25-year time span, has seen numerous changes in programs with which it has worked. The national Medicare program was implemented in July of 1965, six years prior to the founding of the Foundation, which first served as the professional standards review organization (PSRO). The peer review organization designation came July 1, 1984. The Foundation's contract with the Division of Medicaid began in 1984. With processes and procedures ever changing and evolving, the Foundation has worked to promote quality of care under these programs during the ensuing years.

Now, as we face changes in health care more dramatic than ever, there is no better time to look back at our history before moving forward to the future. The Foundation stands ready to work with Mississippians for quality health care.

My years with the Foundation, some 15 or more, first as a review physician, then as part-time medical director and now as a full-time principal clinical coordinator, have enabled me to work with many fine physicians

throughout the state. I hesitate to list them, because there are many and it's too easy to leave out names. The Foundation has grown from its beginnings as an experimental medical review pilot project to the federally designated PRO because of the support of those who have worked as review physicians, served on the board of directors and committees, or simply taken the time to nominate and vote in the annual board of directors election.

The support of a variety of organizations, including the Mississippi Hospital Association and the Mississippi State Medical Association, as well as consumer organizations such as the AARP, has been invaluable, contributing toward making the Foundation unique in the state.❑

James S. McIlwain, Jr., M. D.
Principal Clinical Coordinator

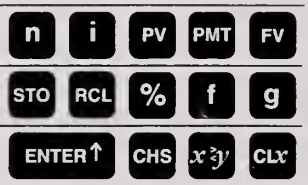
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Physicians' Recognition Award



Five MSMA members were named recipients of the AMA Physicians Recognition Award in May 1996, six in February. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
William Eugene Loper, MD

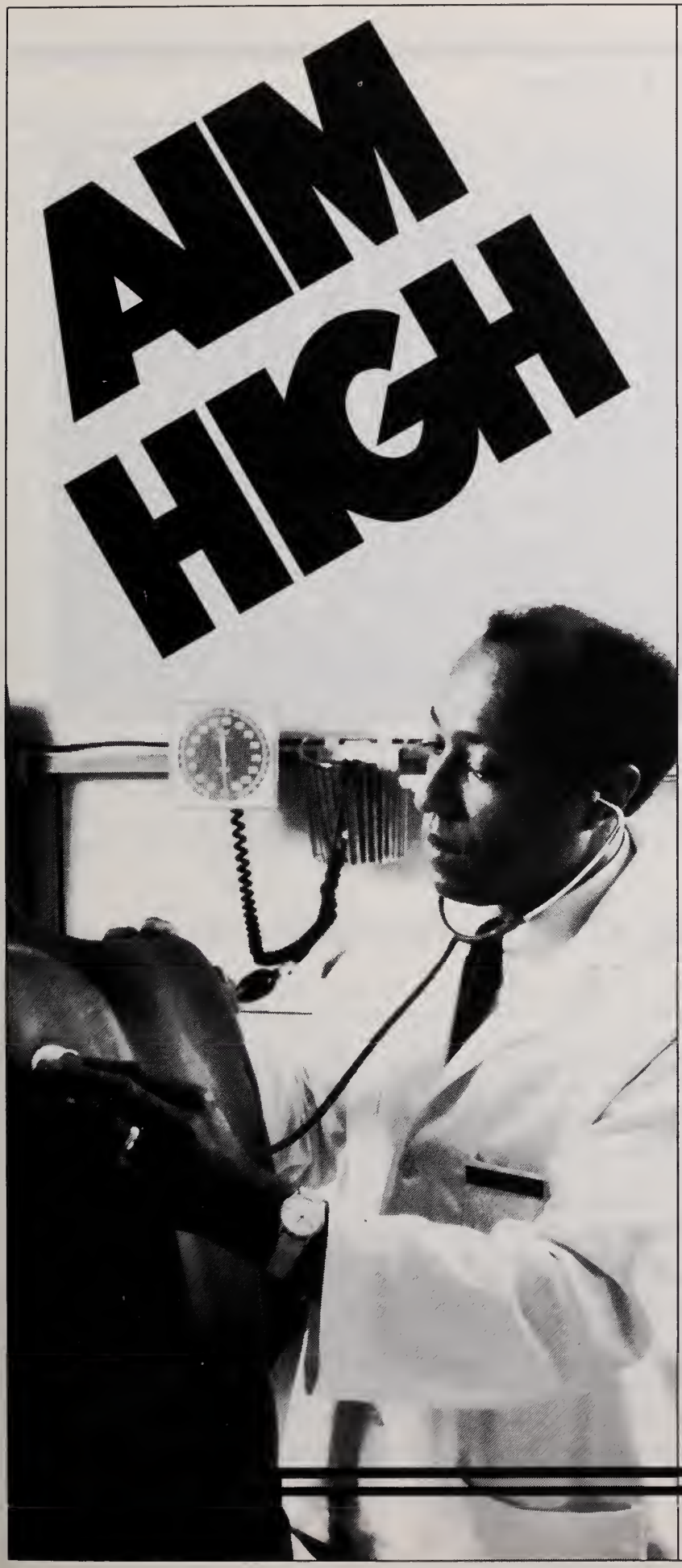
Coast Counties Medical Society
William Otis Henry, MD

Desoto County Medical Society
Paul King, MD

North Mississippi Medical Society
Horton G. Taylor, MD

Northeast Mississippi Medical Society
Kelly S. Segars, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**



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AIR FORCE



The Wiser Hospital, with 173,556 square feet, will have a 10-bed obstetrical emergency unit, a state-of-the-art antenatal diagnostic unit, an obstetric intensive care unit, a 64-bassinet newborn intensive care unit, term nursery, state-of-the-art labor and delivery suite--all occupying the first-third floors. Classrooms, conference rooms and patient rooms--with 93 adult beds- will occupy the third, fourth, fifth, and sixth floor of the building. The new building, with a total budget of $37.5 million, is expected to open in about two years.

UMC to Build Winfred L. Wiser Hospital for Women and Infants

The groundbreaking ceremony for the Winfred L. Wiser Hospital for Women and Infants on May 16 marked the start of a project that had been a dream held in suspension for 15 years. The long wait for the much needed facility was the theme of remarks during the ceremony on the campus of the University of Mississippi Medical Center in Jackson.

In a tribute to the Tennessee native whose name will grace the building, Dr. John Morrison, chairman of ob-gyn, spoke about his long association with Wiser, professor of ob-gyn and former chairman of the department. "Win Wiser was and is my role model. I am proud to have been his student, and will continue learning from him as long as I'm privileged to know him."

Recounting his mentor's 20 years as chairman of the department during which he made the ob-gyn residency one of the most sought after in the country, built a $1.6 million endowment for the department, and laid the groundwork for the spirit of cooperation between University ob-gyns and those in private practice, Morrison said, "Win has worked to improve the health of mothers and babies in Mississippi for more than two decades. In those same 20 years, his voice has rung in countless ears about the need in our state for a hospital that offers comprehensive care for women. His work has paid off. Now we will have the physical facility to match the quality of care that Win teachers--on this very spot."



Ground is broken by ceremony principals. Dr. Wiser is third from left. Wiser is professor of ob-gyn. He was chairman of the department from 1976-1996.

James Luvene, president of the Board of Trustees of State Institutions of Higher Learning, recalled that Dr. Norman C. Nelson, UMC vice-chancellor emeritus, and the late Dr. Porter Fortune, then Ole Miss chancellor, first got board approval to seek state funding for such a building on August 17, 1979. Then board president Bobby Chain urged the governor and lieutenant governor to take "immediate action to combat the critical overcrowding of obstetrical patients at the University."

UMC Vice Chancellor Dr. A. Wallace Conerly said Nelson made a case for a perinatal center many times in the legislature. When it became obvious that state funding "would not be available in the foreseeable future for this or several other critically needed structures on our campus, he developed a three-step plan of action."

The steps included saving onetime reimbursements for patient care, gaining permission to establish the Medical Center Education Building Corporation to sell bonds to fund construction, and a professional estimate of our physical plant needs and the amount of debt we could service on hospital self-generated income.

Dr. Nelson said, "Win and I have grown gray together waiting for this day." Describing the overcrowding in all the hospital units that care for mothers and babies, he said. "We've had to put expectant mothers and babies in the hallways on more occasions than I like to admit."

Ole Miss Chancellor Robert Khayat called it "an historic day in the health sciences center," he said, "will soon have a state-of-the-art woman's hospital."

Wiser is the brother of Mildred Frazier of Murfreesboro; Eunice Driver of Wartrace; Dr. J.E. "Bud" Wiser of Christiana; Dr. Wymer Wiser of Murfreesboro; and Dr. Vernon Wiser of Shelbyville, all in Tennesee.



Right: ***Mark Strong*** *and* ***UMC Vice Chancellor Dr. A. Wallace Conerly.***

Mark Hopkins Strong *from McComb was recognized at the 128th Annual MSMA House of Delegates meeting as the 1996 recipient of the* ***CARL GUSTAV EVERS AWARD.*** *The award is given to a senior medical student who has demonstrated qualities of scholarship, peer to peer support, and exceptional leadership in student activities of the American Medical Association and the Mississippi State Medical Association. The award, established in 1993 by the Mississippi State Medical Association Foundation in memory of Dr. Carl G. Evers, professor of pathology and associate dean for academic affairs who died November 19, 1992 consists of a plaque and a cash prize.*



Right: The award was presented at the University of Mississippi School of Medicine 35th Annual Honors Day ceremony. ***Julie Evers and Jan Evers, daughter and wife respectively, congratulate Mark Strong,*** *along with* ***UMC Vice Chancellor Dr. A. Wallace Conerly.***



Left: ***MSMA President Fred McMillan*** *presented the Mississippi State Medical Association's* ***Award for Excellence in Medical Reporting - Newspaper Category*** *to* ***Ms. Melanie Simpson****, editor of The Daily Mississippian, the Ole Miss student newspaper, in Oxford. The award was presented to Ms. Simpson for her reporting on Human Papilloma Virus (HPV). The two articles, "UM Genital Warts Two Times National Average" and "Real-life HPV From A Patient," addressed the subject as related to campus students.*

The 1995 AWARDS FOR EXCELLENCE IN MEDICAL REPORTING *competition is designed to recognize individuals whose journalistic achievements have contributed to a better understanding of medicine and health care in Mississippi.* ***The award in each category consists of a $500 cash prize and a plaque****. The awards are presented annually by the Mississippi State Medical Association.*



Left: ***MSMA President Fred McMillan*** *presented the Mississippi State Medical Association's* ***Award for Excellence in Medical Reporting - Broadcast Category*** *to* ***Ms. Melanie Christopher****, reporter and news anchor for CBS affiliate WJTV-12 in Jackson, Mississippi. The award was presented to Ms. Christopher for her three-part series on colon cancer. In "The Disease Nobody Wants" To Talk About," it was stressed that this disease is highly curable if detected early. The importance of knowing the warning signs, risk factors and screening recommendations were emphasized, as well as the importance of discussing the colon with your doctor. Each piece featured an individual dealing with a particular aspect of colon cancer. One person was diagnosed with the disease and successfully underwent surgery. Another lost two family members to colon cancer and is clearly at risk for the disease himself. And finally, the third person suffers with polyps, a precursor to colon cancer, and has made serious lifestyle changes.*

New Members

JAH, MOHAMED BOCKARIE, Dekalb. Born Taiama-Sierra Leone August 10, 1952; MD Ain Shams University Medical School, Cairo, Egypt, 1985; interned one year, same; general surgery residency, same, 1983-86; internal medicine residency, Hubbard Hospital and Meharry Medical Center, Nashville, TN, 1990-93; one year fellowship, geriatrics, University of Connecticut Health Center, Farmington, CT; elected by East Mississippi Medical Society.

MARTIN, IRVIN L., III., Meridian. Born Philadelphia, MS, January 25, 1964; MD University of Mississippi School of Medicine, Jackson, MS 1990; orthopaedic residency, Louisiana State University Medical Center, New Orleans, LA, 1990-95; elected by East Mississippi Medical Society.

MILLER, STEVEN J., Ocean Springs. Born Covina, CA, March 15, 1962; MD University of South Alabama Medical School, Mobile, AL, 1987; general surgery residency, University of Washington Hospitals, Seattle, WA, 1987-92; elected by Singing River Medical Society.

MOORE, BLAKE H., Kosciusko. Born September 2, 1964; MD Univeristy of Medicine & Dentistry of New Jersey, New Jersey Medical School, Newark, NJ, 1990; general surgery residency, St Francis Medical Center, Trenton, NJ 1990-95; elected by North Central Medical Society.

ODOM, MAX K., Cleveland. Born Los Angeles, CA, September 4, 1960; MD Louisiana State Univeristy School of Medicine, Shreveport, LA, 1986; internal medicine internship, Baptist Medical Center, New Orleans, LA., general surgery residency, Tulane Medical Center, New Orleans, LA 1992-94; elected by Delta Medical Center.

ROBINSON, CHARLES LEE., Gulfport. Born Kansas, February 22, 1956; MD University of Kansas Medical School, Lawrence-Kansas City, MO, 1982; ob-gyn residency, Saginaw Cooperative Hopsitals, Inc. 1983-86; elected by Coast Counties Medical Society.

DEATHS:

DEES, J. GORDON, Jackson. Born September 26, 1908; MD University of Tennessee School of Medicine, Memphis, TN, 1933; died May 30, 1996, age 87.

JONES, WARREN C., Forest. Born December 25, 1914; MD Tulane University School of Medicine, New Orleans, LA., 1938; died May 6, 1996, age 81.

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Personals

Frank W. Bowen, M.D. has joined the staff of Methodist Medical Center in family medicine at Methodist Family Care Center.

Roger Lowery, M.D., who is a member of the North Mississippi Health Services (NMHS) Executive Committee of the Board of Directors, is serving as chairman of the System Medical Staff Committee. Dr. Lowery is a board-certified otolaryngologist in private practice with Tupelo Ear, Nose and Throat Clinic. Other members of the committee include: **James L. Brown, MD; Charles Montgomery; Charles Ozborn, MD; Scott K. Segars; John Gerald Shields, Jr.; James H. Shirley, MD;** and **Stephen M. Shirley, MD.** The newly created, ad hoc System Medical Staff Committee will provide systematic input on the NMHS health care system.

Alan E. Freeland, M.D., Professor of Orthopaedic Surgery, was on the faculty for a course on "Tissue Loss in the Upper Extremity: Reconstruction and Rehabilitation" at Breckenridge, Colorado, and he also chaired a course on Hand and Wrist Fracture Management and Reconstruction at St. Petersburg Beach, Florida.

Walter R. Shelton, M.D., of Mississippi Sports Medicine and Orthopaedic Center in Jackson, was elected to the Board of Directors of the Arthroscopy Association of North America at its annual meeting in April of this year.

Buddy Savoie, M.D. recently presented the following topics at the Spring Sports Symposium, The Union Memorial Hospital in Baltimore Maryland: "Minimal Incision Tennis Elbow Repair," and "New Concepts in Elbow Arthroscopy Radial Head Excision Capsular Release."

F. Lee Horn, M.D. will be the supervising physician of a new clinic opening to serve Woodland, Mississippi residents. Located in the former city hall, the South Chickisaw Health Clinic will also be staffed with an LPN and a receptionist.

Bennie Wright, M.D., Cleveland general surgeon, attended the American College of General Surgeons annual meeting in New York City. He attended as a representative of the General Surgeons of Mississippi, of which is he president. Approximately 1,000 surgeons attended the meeting. Some of the topics addressed were Managed Care and impending legislation. Dr. Wright also met with Senator Frist of Tennessee.

William D. Frazier M.D. announces the opening of Jackson Lung Clinic, Suite 304, Medical Arts Building West, Jackson, Mississippi 39202.

The late **P. K. Thomas, Jr., M.D.,** former Tupelo physician, has had a Habitat home dedicated in his memory by North Mississippi Health Services, in conjunction with Habitat for Humanity. They are sponsoring another house for a hospital employee who will be chosen by the Habitat Selection Committee.

Fred Y. Grant, M.D., an obstetrician/gynecologist with Rush Medical Group P.A. of Meridian, has successfully completed the certification renewal evaluation process of the American Board of Obstetrics and Gynecology, and is a newly recertified diplomate of the board.

Dominic Cannella, M.D. announces the opening of his medical practice of Neurosurgery associated with Tupelo Neurosurgery Clinic.

Paul Allen, M.D., a gynecologist and obstetrician, practicing in Pascagoula, attended the Masters OLULA Course in Tuskegee University in Tuskegee, Alabama. The course was designed to instruct physicians in the technique of office laparoscopy under local anesthesia. The OLULA methods and techniques can be adapted for diagnostic procedures with pain mapping and for surgical sterilization in female patients. Dr. Allen gave a special presentation at the Masters OLULA Course on office based surgical facility accreditation and on his development of the nation's first publicly held obstetrics and gynecology single specialty practice management corporation (PMC) which he plans to take public in an initial public of-

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

fering (IPO) on the NASDAQ stock exchange in the near future. Thirty-three gynecologists participated in this teaching program. Dr. Allen is serving as Chief of Staff Elect and Medical Director of Continuing Medical Education at Singing River Hospital in Pascagoula.

Linda Ray, M.D., assistant professor of pediatrics, spoke at the Southern Regional Juvenile Arthritis and Rheumatic Disease Family Retreat in Shreveport, Louisiana.

James Martin, M.D., ob-gyn professor, spoke at the postgraduate course during the Arkansas section meeting of the American College of Obstetricians and Gynecologists in Eureka Springs, Arkansas. He also gave grand rounds at the Mountain Area Health Education Center in Asheville, North Carolina.

A. Wallace Conerly, M.D., vice chancellor for health affairs at the University of Mississippi Medical Center, announced faculty promotions in the Schools of Medicine, effective July 1, following approval by the Board of Trustees of State Institutions of Higher Learning. Promoted to the rank of professor in the medical school were **Robert L. Galli, M.D.** (emergency medicine), **Patricia Norman, M.D.** (anesthesiology) and **Ames F. Tryon , M.D.** (medicine). Medical school faculty promoted to associate professor included **Carolyn L. Bigelow, M.D.** (medicine), **Claude D. Brunson, M.D.** (anesthesiology), **Robert C. Forbes, M.D.** (family medicine), **David Lee Gordon, M.D.** (neurology), **Harold M. Henderson, M.D.** (medicine), **Robin D. Issacs, M.D.** (medicine), **Kenneth G. Perry, M.D.** (obstetrics-gynecology), and **M. P. "Dick" Smith, M.D.** (medicine).

H. McLean Jarmon, Jr., MD, of Vicksburg, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Parkview Regional Medical Center. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Dr. Jarmon is among a national network of over 2,000 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities. Dr. Jarmon, who has a significant interest in the diagnosis and treatment of patients with malignant diseases, also provides local leadership for the annual national clinical goal of the Cancer Liaison Program. This year's goal is a joint effort by the Commission on Cancer and the American Cancer Society to impact the prevention of tobacco-related cancer and other diseases in the childhood and young adult population.

Donald E. Doyle, M.D., cosmetic surgeon, was featured in a *Mississippi Press* article for his successes as an inventor. The doctor-inventor who has made cosmetic surgery less painful for patients and easier for surgeons presently holds six patents and has four more pending. "I'll get a seventh patent in May, and then I'll have three more pending. So far, I have one that's outside of medicine," Doyle said. "The one outside medicine is for shaving. It's a new way to hold a blade against your face, so that you have better control. You can get around angles better." Doyle is credited for inventing the Doyle Nasal Tampon, the Staxi-Stat, Intranasal Airway Splint and other practical breakthroughs. He began inventing in 1972, when he was in the first year of his otolaryngology residency.

John H. Eichhorn, M.D., chairman of anesthesiology, was visiting professor at the 14th annual Can-Am Clinical Anesthesia Conference in Ontario, Canada, where he spoke on "Risk Management in Anesthesia." The conference was presented by the McMaster University in collaboration with the State University of New York at Buffalo.

Tom McLees, M.D., of Corinth, was recognized by a local agency, in observance of National Volunteer Week, for his dedication to Superior Hospice. "We did not have funds to hire a medical director, but could not operate the program without that individual," said Superior Home Health/ Hospice Director June Peters. "Dr. Tom McLees learned of our dilemma and offered his service in the role of hospice medical director at no cost to the Program. This is the position he has held since 1990, donating countless hours to the program and attending hospice workshops at his own expense." McLees attends an interdisciplinary team meeting every other week, offers advice and educational information to the hospice team, is available for on-call consultation to the nurses, as well as communicating with the primary physician as needed. He is also a member of the Professional Advisory Committee for home health and hospice.

Julius Cruse, M.D., professor of pathology, presented a paper at the joint meeting of the American Association of Immunologists and the American Society for Investigative Pathology in New Orleans.

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P. John Seward, MD

The AMA's new EVP talks about his vision for the future.

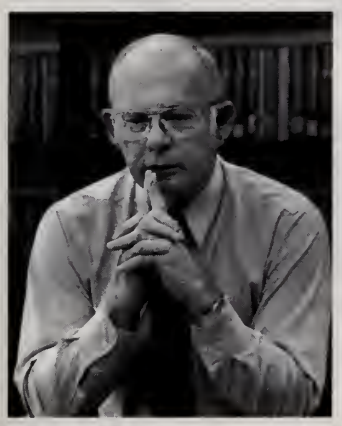


Photo by: Ted Grudzinski

What is your vision for the AMA?

To continue to reinforce our role as the primary national advocate for patients and physicians. In the most fundamental way, that is what medicine is all about. And the AMA can act on behalf of millions of patients. We continue in a good position to do this. We are financially secure and programmatically sound. We are strongly positioned as medicine's leader, and I see us continuing in that role.

How has your background prepared you for your current role as EVP?

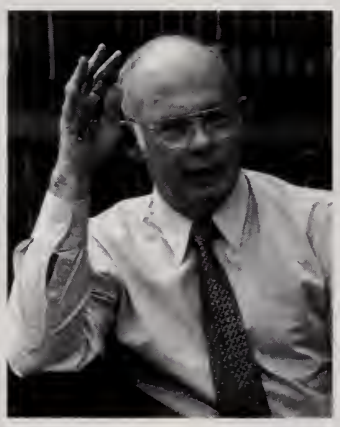
I was a practicing doctor, with all the joys, problems, hassles, and tears that practicing medicine brings. I've also been the manager of a number of successful business enterprises and a longtime public official. All of this and my service as member and chair of the AMA have given me enormous experience and perspective for assuming this new role.

Some physicians are reluctant to join the AMA because they don't believe it represents their interests. What will you do about that?

The AMA currently represents physicians' interests. We have represented physicians in Washington on issues of health system reform, Medicare and professional liability, we have led the charge in public health issues such as domestic violence and tobacco, and we are currently evaluating the Federation and how it can better serve the needs of physicians and their patients. If physicians don't believe we are representing their interests, then we have to look at how we are delivering our message. We need to articulate and communicate the value of membership in a better way.

More and more women and minorities are becoming physicians. What is their incentive to join the AMA?

These are physicians whose talents and dedication will make health care better for all of us. Their incentive to join is representation and a chance to be an active participant in the changes in medicine as we prepare for the 21st century. The AMA has more female physician members than any other medical professional organization. We have a woman chair, Nancy Dickey, MD, for the first time in AMA history. We have Palma Formica, MD, and Regina Benjamin, MD, on the Board. We are seeing an increase in membership among minorities and international medical graduates because the AMA is seen as a solution to the hassles that they are facing.



The Federation study suggests changes in representation from state, county, and specialty societies. Will these changes significantly affect membership?

The AMA is a dynamic organization. We have been changing for years. The Federation study is just part of that change. The purpose of the Federation study is to give practicing physicians input in how their societies make policy so that they do not feel shut out. I believe that membership will increase as a result of the study.

How will the AMA help doctors educate patients about changes in Medicare and Medicaid?

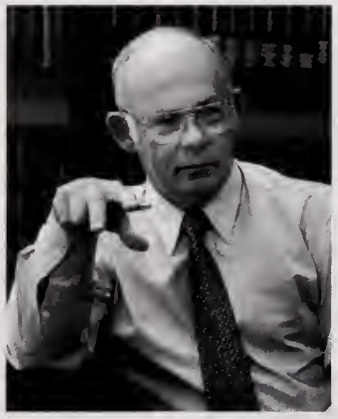
We will work with the media – sending our Board members to editorial boards and radio and TV stations across the country to broadcast our message. We will provide members with updates on all our Medicare activities as we implement them. As we have always done, we will listen to physician input about our policies and work with America's physicians to bring about the best in health care for their patients.

Will the AMA continue public education and awareness programs on tobacco and domestic violence and other public health activities?

Definitely. Public education and public health have been

major AMA activities since our founding 150 years ago. As a Florida newspaper editorial said, maybe we don't really need a US Surgeon General as long as the AMA is around. The AMA is a recognized voice in public health issues and we take that responsibility very seriously.

How will the AMA help physicians gain more control over their careers during this time of change in physician's practice environments?



By continuing to inform physicians about our actions in Washington, about the environment in which they practice and about the best ways in which they can take control of their medical practice.

What are the AMA's 1996 legislative and political goals?

We still will be concerned with the issues we pursued in 1995. Last year was very busy, legislatively. We staked out our territory and stuck to it: Medicare, liability reform, doing away with hassles like Stark I and Stark II, CLIA and patient protections. We made tremendous headway. That agenda is still as cogent for 1996 as it was for 1995. If anything, the need to accomplish it is even higher. Just getting close doesn't excite me much. Now we have to say - "we can do it!"

You were the elected county coroner for 23 years. How did that prepare you for AMA leadership?

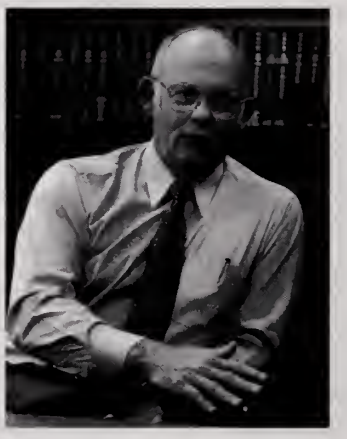
An old friend of mine taught me that good politics is good service, and good service is good politics. You had to earn their trust every day. It humbled me. It taught me to keep an open mind. Any time I jumped to conclusions, I was absolutely wrong. Team work is very important; you can't do it alone. I look at this job the same way. An EVP isn't supposed to be a hero. If anything, I would classify myself as a "designer" of bringing people together, helping inspire our team to do a better job.

How do you see the practice of medicine changing?

Medicine in some ways hasn't changed at all. It's still about providing the best care to individual patients. In other ways, it's changing hugely in what we can do for those patients. The cost of health care will continue to be a major issue. Anytime you upgrade, you create new concerns, specifically ethical ones. Will our ethics be able to keep up with how we apply technology to our practices? As professionals, we have to be leaders in this because it's our duty. The AMA has to help our physicians say, yes, we are still on course, but we are also advancing.

How will the AMA work to overcome the loss of collegiality and unite physicians in the future?

I'm an eternal optimist. Is collegiality irretrievably lost? I don't think so. As physicians, we all have so much in common – our devotion to medicine and to our patients, and the problems that affect us all in the practice of medicine. I'm confident that we have the motivation and the desire to work together. When you talk to physicians who are saddened, anxious and depressed, it doesn't matter what type of health care delivery system they're practicing in, they are still physicians. This is where the AMA can be the catalyst to redefine who and what we are. To show we all need to work together. This is a legacy issue. I want to make sure we leave the profession better off than what we found it. This is how I want to be measured.



How will your role differ from that of your predecessors?

I'm different and the times are different. The information age has brought everybody closer. When somebody sneezes in Seoul, Korea, it affects me in Rockford, Illinois. It's the same medicine. The AMA must continue to be better focused, more receptive, more efficient. We do not have the luxury of contemplation and inaction. We have to be faster on our feet.

What about Medicare reform?

The AMA is committed to transforming Medicare. We'll stay the course. The proposals we gave to Congress are still on the agenda. Patient choice. Quality of care. Physician-sponsored networks. Patient protection, medical liability, reform, relief from Stark I and Stark II, CLIA.

What about Medicaid Reform?

We want to make sure this vulnerable group receives adequate and appropriate care. They're patients. They're also family, neighbors, and friends. Standards have to be maintained to make sure that they do obtain care, whether it's by "block grants" or some other mechanism. We also have to consider long term care. On this and so many other critical issues, the AMA has to be a watchdog. We have to help define the road the country needs to take if all our patients are to get the care they need. ◆

Interview by Linda Stepanich.



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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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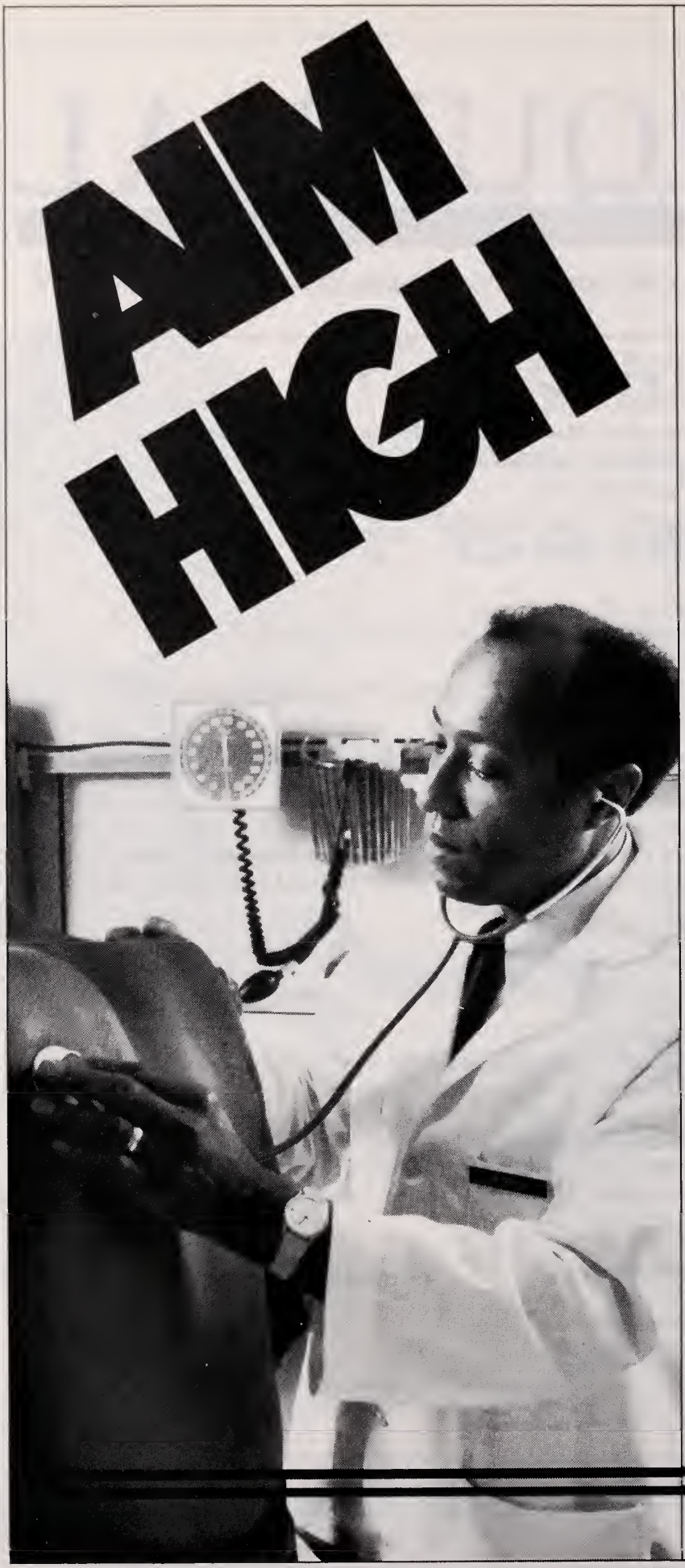
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Community-Based Internal Medicine Residency Training- A Report on our First Two Years

J. Paul White, M.D.
Shirley D. Schlessinger, M.D.
John B. O'Connell, M.D.

Abstract

Since August, 1993, Internal Medicine Associates Foundation, Inc. of Tupelo and the Department of Medicine, University of Mississippi Medical Center, have been cooperating in a program of community-based Internal Medicine residency training, the first effort of its kind in the state. We are pleased to report the program an unqualified success, for the residents themselves, the participating private physicians, and the Department as a whole. As one of only a handful of ambulatory care private practice relationships in the country (approximately five percent of Internal Medicine departments have such at present) [1], we feel that ours can serve as a model for other programs to emulate. We therefore present a report on our program's background, organizational structure, curriculum, and future plans.

Background: Fulfilling a Need

As part of the larger picture of evolving trends in medical education, the Tupelo Ambulatory Care rotation is an important example of the increased emphasis on primary care training. In response to the call for more generalists in Internal Medicine, our program answers both departmental needs and local physician recruitment goals. The origin of the Tupelo rotation can be traced to these simultaneous needs of the Department of Medicine and the local medical community in Tupelo for ambulatory training.

As one facet of restructuring and revitalization of the University of Mississippi Medical Center's Department of Medicine, plans were made to incorporate residency training and private practice affiliations. The Chairman's Advisory Committee was developed consisting of internists from around the state who would be asked to meet periodically with the chairman (JBOC) to discuss issues pertinent to the Department's role in furnishing internists and specialists for Mississippi. At one of these meetings in 1992, the idea of allowing residents to rotate with internists in private practice was proposed, with the emphasis to be entirely on ambulatory care and office practice.

Current ACGME requirements for Internal Medicine training specify "at least twenty-five percent of the three years of residency training must be in the ambulatory care setting".[2] This rotation could help fulfill a specific training requirement for the residents. In addition, the community-based ambulatory rotation is an

attractive recruiting element for a training program and might serve to stimulate medical student interest in the UMMC Internal Medicine residency program.

Internal Medicine Associates (IMA) of Tupelo, the state's largest Internal Medicine group, was the first to respond, developing a month long rotation plan which was enthusiastically received and adopted by the Department of Medicine. The relationship of Tupelo with the University of Mississippi Medical Center was not novel since residents in both Surgery and Obstetrics and Gynecology had been working with private practice Tupelo physicians in these fields for several years. These, however, had been primarily hospital-based rotations. From IMA's standpoint, the most pressing need for involvement in such a program was that of recruitment of new staff. General internists were becoming an increasingly rare commodity, and projected needs for internists in Tupelo alone—not including satellite affiliations in nearby communities—were far greater than the available supply.

Exposing residents to both a practice opportunity and a favorable community setting, would naturally enhance recruitment potential. Internal Medicine residents traditionally remain within the state where they train. In one study, more than 40 percent of residents moved less than ten miles for their first practice site, with more than 50 percent staying within 75 miles of their residency location.[3] Furthermore, evidence confirming the importance of early exposure to primary care in influencing both medical students and residents in selecting careers was accumulating.[4-6] The course of action was clear that design and implementation of an attractive rotation for Internal Medicine residents would require an unconditional commitment from both parties for success.

IMA: Clinic Structure

At the time of the program's initiation, Internal Medicine Associates consisted of twenty-two physicians, comprising general internists, cardiologists, gastroenterologists, pulmonologists, and an infectious disease specialist. The group had been founded in 1977 when Drs. Eugene Murphey and William Wood joined with Drs. F.L. Lummus and Antone Tannehill. Growth and expansion culminated in 1993 with the formation of Internal Medicine Associate Foundation, a not-for-profit medical foundation operating as a cooperative venture between IMA and North Mississippi Medical Center. The move was heralded as a landmark achievement in progressive medical care.[7-9]

Currently, IMA employs thirty-six physicians and approximately 200 other employees with affiliated clinics in Corinth, West Point, Starkville, and Hamilton, Alabama. Management agreements have been developed with Internal Medicine groups in New Albany and Columbus. The clinic's main office in Tupelo is a 35,000 square foot facility with outpatient gastroenterology and cardiology services in addition to physician office space. Growth has required additional office space for business and support personnel in three separate nearby buildings. Up-to-date management techniques have facilitated our expansion and ensured financial success and security.

The adaptation of resident training into this clinic structure has been accomplished through careful planning followed by active and enthusiastic participation by both physicians and administrative personnel. Since its inception, leadership and oversight have been entrusted to one of the clinic's internists, who serves as Program Director (JPW), and an Administrative Coordinator from the clinic's management team. Five designated internists serve as preceptors for the residents, working on a monthly rotating basis, while various subspecialists likewise assume teaching roles on a rotating schedule.

Course Description and Curriculum

In developing course guidelines and curriculum, the principal goal was to provide residents with an opportunity to obtain private practice experience in Internal Medicine through direct participation in an ambulatory care setting. The program's curriculum was developed utilizing input from clinic physicians and also recommendations from the Department of Medicine. A formal written curriculum was submitted to the Department and approved. The report from the Residency Review Committee for Internal Medicine, at their 1994 visit to UMMC, was likewise beneficial in drawing up proper program standards. Last, but not least, feedback from the residents themselves has been of considerable value in making the rotation both rewarding and enjoyable.

As noted, a group of internists serves as the core of the program, working as Preceptors for the individual residents. All board-certified in Internal Medicine, these physicians are approved by the Department of Medicine and are granted the status of Clinical Assistant Professor of Medicine by the University of Mississippi Medical Center. (These appointments are nonsalaried.) Preceptors are encouraged to work closely with their individual residents during the month and to involve them in all aspects of their practice; their position as role model is felt to be a critical component of the teaching experience.

The majority of the resident's time is designated with their Preceptor during regular clinic hours, Monday through Friday. The week actually begins at noon on

Mondays and ends at noon on Fridays to allow residents easier travel time to and from Jackson. Each house officer is furnished a Resident's Handbook which contains daily schedules for the month, preceptor guidelines, educational objectives for each specialty area, and other additional information such as pertinent phone numbers and a map of the city. Time is allotted on the first day for orientation by the Preceptors and their nurses; the Administrative Coordinator sees to the distribution of necessary items such as parking cards, keys, dictaphones, and schedules.

Residents evaluate the usual variety of outpatient medical problems with the general internists. The daily appointment schedule includes a mix of established patients returning for routine follow-up, "Acute Care" patients seen for same-day problems, and new patients presenting for initial evaluation. Patients are told resident physicians participate in the practice and are given the option of seeing a resident. If the patient agrees, the resident is then asked to assess the patient as his / her own new patient, proceeding with the appropriate history and physical examination as indicated. Each patient is then presented to the Preceptor and discussed, with emphasis on the resident's ideas for treatment plans. These treatment suggestions are then brought to the patient by the two physicians and discussed. Dictation of office notes, prescription writing, ordering of laboratory and x-ray procedures, encounter form preparation, and even referral letters are the resident's responsibility as part of each patient visit. When possible, new patients are given a follow-up visit the same month to allow for continuity of care and the assessment of new treatments. Other areas of a general internist's practice, such as telephone management of call-in problems, home health nursing issues and handling paperwork efficiently are also dealt with, usually on a daily basis.

The clinic's subspecialists have responded well to their new teaching roles, with most medicine subspecialty areas represented. Half-day sessions are interspersed throughout the monthly schedule. Cardiology, Gastroenterology, Pulmonary, Infectious Diseases, and Rheumatology all participate and have tried to focus on educational objectives of benefit to a general internist. For residents wishing to pursue specialty training, additional time can usually be allotted in their area of interest.

An additional educational experience for residents while in Tupelo is provided at the Good Samaritan Clinic, a free-standing health clinic providing healthcare to the "working poor" of Lee County. Created in 1992, the clinic was the culmination of several years of effort and inspiration by physicians and community leaders seeking to address health care for many of the poor and uninsured. This added responsibility has proved to be particularly popular with the house staff.

The last area of teaching which we have developed is in the area of office management. The clinic administrator and several support personnel from the management team present basic facets of ICD-9 codes, Medicare and private insurance billing, encounter form completion, intensity levels of visits, collections, personnel management and managed care contracts. Additional time is spent with the lab director to discuss lab operations, OSHA regulations and CLIA guidelines. Weekly management team meetings are attended by the residents, and the ideas behind Total Quality Management are explained.

As each resident completes the month-long rotation, he/she meets with the Program Director for a formal exit interview to discuss their Tupelo experience. Likes and dislikes and suggestions for change are continually considered as means of improvement for future participants. The preceptor evaluates each resident using the standard ABIM resident evaluation form and forwards those forms to the Department office in Jackson. Residents? Likewise, complete written evaluations of the Tupelo rotation.

Educational Conferences

With a less strenuous and somewhat more relaxed rotation than the usual inpatient services, residents have also been able to spend time in reading and board review. Numerous educational conferences are available to the medical community in Tupelo, and the residency program has provided a boost in this area in the form of Grand Rounds. Although a common opportunity at most hospitals, no formal Grand Rounds existed at North Mississippi Medical Center until it was created as part of our teaching program. Residents are required to prepare a case presentation, with two cases presented at month's end at Grand Rounds. The medical staff benefits from an educational perspective, while the residents benefit from experience in research, slide preparation, and public speaking.

Two other conferences are considered mandatory during the month. The newest of these is Internal Medicine Journal Club, which began in the Fall of 1995. Residents participate in this by critique of relevant articles. The hospital's Ethics Committee holds monthly breakfast meetings, often with guest speakers from the field of medical ethics and residents are required to attend. Residents also join the medical staff in attending weekly Tumor Conferences, featuring case presentations

by members of the Surgical and Oncology staff. Other evening Continuing Medical Education meetings are usually available each month' and these are listed on the resident's schedule.

Economic Considerations

The formal relationship between University Medical Center and IMA was established in 1993 with signing of an agreement between the two parties. The initial relationship provided that IMA would provide a monthly stipend along with lodging and meals; the group also agreed to reimburse the Medical Center for the cost of professional liability insurance for the residents. With the success of the rotation and the shrinking dollars at a national level for graduate medical education, financial support for the Tupelo rotation was assumed by IMA in January, 1995.

Currently expenditures for two residents monthly are $78,784 per year. Lodging is provided at two furnished two-bedroom duplexes; monthly rent for these is $425 and is funded by the hospital. Residents continue to receive a monthly stipend of $1000. No direct allocation is made for meals, although the residents may eat any meal free of charge at the hospital cafeteria and may have lunch daily in the hospital's doctor's lounge.

Physicians participating in the program, especially the preceptors, have seen no effect on their production figures or income from time spent with the residents. Office charges for patients seen by the particular resident are made under the preceptor's name. We have not made an effort at this point to tabulate separate charge totals for residents each month, nor have total patient visits per resident been tracked on a monthly basis. If only for academic interest, such data may be available in the future.

Conclusions

Though still in its infancy, the "Tupelo rotation" is continuing to show positive results both locally and on a departmental level in Jackson. The clinic's patient population has adapted well to the resident's involvement in their care, with some patients now being followed regularly by a physician who first saw them as a resident. Recruitment goals have been met nicely, with two internists coming from the first year of the program and three more signing on after this past year. The added exposure to general internal medicine has perhaps played a part in the swing away from specialization among current house staff. In the last two years, approximately 65 percent of Internal Medicine House officers have entered general medicine practice on completion of training as opposed to 35-40 percent historically. The Department of Medicine has also been extremely successful in recruiting the last two years with more house officers currently than ever in the history of the training program. The addition of the Tupelo rotation has almost certainly played a role in this recruitment success. Evaluations of their experience at IMA by the residents have generally been very favorable.

The Department of Medicine and IMA are hoping that future years will be as successful as the first two of their affiliation. The involved parties continue to look for areas of improvement and to meet and discuss issues on a regular basis. Expansion plans may include fourth-year medical students or optional time for the residents at one of IMA's smaller affiliated clinics. A separate freestanding Resident's Clinic, such as operated by the University of Virginia, is another possibility. [10]

The changing tides of medical education require constant attention to ways to broaden the skills and improve the training of our future physicians. We feel that community-based residency programs offer an excellent opportunity to enhance the basics of general internal medicine education. It is clear that the complexities of graduate medical education are such that we will no longer be able to provide all of the training necessary to prepare young physicians for the world in which they will be practicing without using a multi-institutional approach.

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Recovery From Aphasia

L. Judson Farmer, Ph.D.

Introduction

For a long time, literature on aphasia has dealt with the topic of recovery from the language and speech deficits sometimes experienced by patients who have had left middle artery CVA. Primary emphases in some of this research have been questions related to several areas which occur frequently in the literature on recovery of language following stroke: (1) "spontaneous recovery," (2) "patterns of recovery," (3) "evolution of aphasia syndromes," and (3) "when speech/language therapy should begin". This paper is concerned to explore some of these questions.

Spontaneous Recovery

This term refers to observed improvement in the language and speech of aphasic patients prior to intervention - other than the usual life saving measures, medical treatments, and family or social agency support.[1,2] It has been pointed out[3] that this improvement or recovery of language function is not actually "spontaneous," but may occur over a period of days, weeks, or months. Sands, Sarno, & Shankweiler[4] contend that spontaneous recovery may last from three to six months Schuell[5] recommended that speech therapy be withheld until this time has passed, otherwise, one could not be sure that patient recovery was due to intervention.

The topic of spontaneous recovery has generated significant research. One of the problems has been to distinguish between aphasia due to strokes and that caused by other types of pathology such as subdural hematoma or transient ischemic episodes which usually make rapid recovery. In addition, it is well known that aphasia due to closed head trauma or causes other than stroke usually makes a faster and more complete recovery than that resulting from CVA.[7,8,9,10]

With regard to recovery of language function in stroke patients over time, the picture is less clear. While the phenomenon of spontaneous recovery is nearly universally acknowledged[11,12, 13,14] questions such as why recovery occurs, when it begins, how long "spontaneous" is, which language functions recover first, how aphasia syndromes evolve, which factors promote recovery, how recovery is measured, and when therapy should begin have not been definitively resolved.

There are some generalities: (1) The shorter the time and the more the degree of early recovery, the better the prognosis. (2) Some degree of motor function may

precede improvement in language.[16] (3) Auditory comprehension improves before speech.[17,18,19] (4) The more severe the aphasia initially, the less satisfactory the recovery.[20,21]

There has also been a fair amount of speculation and research on the anatomical and physiological factors responsible for recovery from the symptoms of stroke. A number of reports represent a broad spectrum of thinking on the question. Lashley[22] was among the first to suggest that one factor limiting recovery was the size of the lesion and that undamaged portions of the affected and unaffected cerebral cortices may assume the functions of the damaged sections. Rubens[23] thought there might be healing of damaged brain tissue and that decreased cerebral edema and an increase in blood perfusion contributed to improved smptomatology. Kertesz,[24] on the basis of CT scans, indicated that there is in many cases, a reduction in the size of the lesion over time. He also agreed with the earlier ideas that positive changes in cerebral physiology influence recovery.

What is the length of "spontaneous" recovery? From a large number of studies which directly or indirectly comment on this question, several have been selected for review. Henley, Pettit, Todd-Pokropek et al[25], studied 170 patients and found that the degree of language recovery two weeks after onset was the best predictor of status at one year post CVA. Holland[26] and her colleagues found that after an initial rapid recovery of part or all of the language function, progress leveled off. However, small, noticeable changes could be observed up to one year.

Marshall and Phillips[27], in an effort to establish predictors for recovery, found that "terminal speech performance" correlated with postonset months. Three to six months was the length of spontaneous recovery agreed on by Reinvang & Envik, Demeurisse, et al, and Wade, Wood, & Hewer.[28, 29, 30] Lendrum & Lincoln[31] observed recovery in patients from 4 to 36 weeks, while Samples & Lane[32] reported a case of global aphasia where recovery continued to be noted during a period of three years. These studies suggest a lack of agreement regarding the time in which spontaneous recovery may be observed.

Can spontaneous recovery be measured? Since the basic definition indicates that it occurs prior to rehabilitative intervention, it might be possible to ascertain the degree of naturally occurring recovery by performing tests of some functions as soon after onset as possible (assuming normal premorbid communicative ability), and again at intervals after onset. Sarno & Sarno[33] believed this could be done most readily by assessment of ADL (activities of daily living) The conclusion was that improvement in ability to perform these functions was a satisfactory measurement of spontaneous recovery. This work led to the genesis of the Functional Communication Profile.

Functional Communication Profile

Hartman[34] suggested that a series of relatively simple tests conducted at the bedside by the neurologist could adequately determine the degree of spontaneous change and supply information regarding the type of aphasia and its evolution These tasks included object naming, single word reading, following directions and giving personal information. Similar tasks form the basis of many published tests for aphasia. The use of standardized tests for this purpose has been questioned,[35,36] since they are usually given after the spontaneous recovery period is presumed to have passed.

A final point in the consideration of the recovery time factor is the influence of modern technology, particularly the CT scan, on the study of time related events. Yarnell, Monroe, & Sobel[37] were among the first to note that spontaneous (natural) recovery from aphasia was often accompanied by changes in the cerebral lesion which could be recorded by CT scan. Their primary observation was that many lesions resolved or were reduced in size. Naeser & Hayward[38], studying one patient, made serial CT scans and found that as the language deficit resolved over a period of three months, the observable lesion became less apparent. Their tentative conclusion was that recovery depends at least partially on direct healing of cerebral tissue. In a longitudinal study of speech recovery in 54 aphasic subjects, Knopman et al[39] correlated CT scans with "speech fluency" assessments at monthly intervals for five months after onset. They found that the degree of speech deficit was related to site and size of the lesion and that the patients who recovered more quickly had some reduction of lesion size. In a similar type of study for single word comprehension, Selnes and associates[40,41] studied 37 patients concluding that small, resolving lesions were related to reduction in the auditory symptoms of aphasia.

Observation of the varying conclusions on the length of time of natural "spontaneous" recovery, and the ways in which it may occur indicates that additional research might be beneficial, particularly when communicative intervention should begin.

Patterns Of Recovery

Wapner & Gardner[42] observed that after three months, the most noticeable patient response to tests was

the ability to reject inappropriate stimuli. They felt this may represent a "pattern of recovery." Kertesz & McCabe[43] and Lomas & Kertesz[44] studied groups of aphasic patients and noted that recovery patterns seemed to depend on elements such as age, initial severity, presence of hemiparesis, and time after onset. Kenin & Swisher[45] reviewed a number of studies on patterns of recovery and concluded (a) most "spontaneous" recovery took place in the first month, (b) less initially aphasic patients showed the best relative recovery, and (c) speech deficits remained more pronounced than comprehension.

Wepman[46] made a unique contribution to the recovery pattern literature by determining that a patient's ability to self correct has a direct correlation to ultimate gains in language ability. This observation has become a standard indicator used by speech pathologists in prognostic statements, and is included in some form in many tests of aphasia.

Evolution Of Syndromes

The "evolution of aphasic syndromes" is described by Vignolo[47] as a term to denote changes in language modality functions which appear to take place in the time after onset. Conclusions from a retrospective study were that patients recovering from aphasia "evolved" from one set of symptoms to another. For example, a patient who was initially globally aphasic might, at a later time, show less difficulty with auditory comprehension and more with speech. Later, Mohr, Sidman, & Stoddard et al[48] observed that aphasic patients seemed to progress through a "sequential deficit profile" which included (a) initial mutism, (b) emergence of naming, (c) superiority of written over oral language, and (d) better performance on picture naming than on oral reading. They maintained that terms such as "Wernicke's and "Broca's" aphasia were valid descriptions of syndromes of aphasia and that deficits evolved within these syndromes. Kertesz & Gill and Schecter, & Bergman[49,50] reviewed the history of "evolutionary" thinking and agreed (1) Global aphasia recovers toward persistent Broca's aphasia. (2) Broca's aphasia frequently recovers into a mild deficit in word finding and dysfluency (3) Wernicke's aphasia often persists or evolves toward a form of conduction or anomia aphasia. (4) Conduction and transcortical aphasia evolve toward anomia and usually have a complete recovery. (5) Anomia is the end stage of many aphasias and usually recovers.

Speech/Language Therapy

This is a factor explored by many writers. It is not the intent of this discussion to make a comprehensive delineation, but to point out that questions remain as to the appropriate therapy initiation time. The question of whether therapy is beneficial is a subject for another paper.

When should the communicative intervention process (speech therapy) begin? Voinescu & Gheorghi[51] studied 50 patients, half of whom received therapy beginning 3 months after onset, and the others "as soon as it was medically feasible." They concluded that a better communicative result is obtained by waiting untilthe end of the spontaneous recovery period. Conversely, in a study of 30 patients, Hayes & Carroll[52] found that early intervention (72 hours after onset) decreased hospital stay time and improved outcome.

Eisenson and Darley[15,36] agree that therapy should begin "as soon as the patient is alert, takes note of surroundings, and gives some degree of cooperation." These factors have some impact for this paper In the writer's view,testing (other than informal conversational assessment) and intervention should begin only when the medical condition is "stable" and the patient is "comfortable." Among other things, this implies being free of IV and nasogastric tubes. It must be assumed that speech pathologists will wait until the patient is alert and oriented before initiating remedial procedures for speech and language.

Conclusion

On the basis of literature and clinical practice, some conclusions appear warranted. 1. Spontaneous recovery is a phenomenon which most aphasic patients experience to a greater or lesser degree. 2. There are consistent observable patterns of recovery in aphasic patients. 3. Recovery from aphasia evolves from one set of symptoms to another. 4. Speech/language therapy should begin when the patient is medically stable, comfortable, and alert enough to respond to test and therapy procedures.

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Organ Donation and Recovery in Mississippi: Update 1996

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Abstract

Over the last 10 years, solid organ transplantation has become increasingly successful and, in 1996, is the recognized standard of care for many end-stage organ diseases. Unfortunately, as this therapy has become more desirable, the demand for transplants has far outpaced the available supply of transplantable organs. Advances in organ preservation, surgical recovery techniques, centralized placement services and communication systems, as well as increased public awareness of the need have helped to increase organ availability. In addition, many transplant programs are now willing to make use of organs from "marginal" or "expanded" donors, particularly in urgent settings for liver and heart transplant recipients.

The primary source of organs for Mississippi patients awaiting transplants is Mississippi donors. The Mississippi Organ Recovery Agency, an independent, non-profit agency, is the federally designated recovery organization for the state of Mississippi. This agency and the wait-listed recipients of the University of Mississippi Medical Center's Transplant Programs are critically dependent on appropriate recognition and referral of potential donors by the health professionals of Mississippi. Historically, Mississippi has one of the lowest organ donation rates in the United States. This will only change if physicians make every effort to offer their patients the option of organ and tissue donation, and if the organ and tissue recovery programs are successful in ongoing educational projects for health professionals and the general public.

Key words: transplantation, organ donation, health care legislation

The Need

The science of solid organ transplantation has made great strides across the last several decades. One year national kidney allograft survival rates of 81%, and patient survival rates of 93%, 79%, 82%, and 72% respectively for kidney, liver, heart and lung transplantation were recorded in 1993 (see Table 1, page 686).

As transplantation has come to be recognized as standard therapy for many end-stage organ diseases, the demand for this medical service has increased exponentially. In December 1988, sixteen thousand and twenty-six people were awaiting a solid organ transplant in the

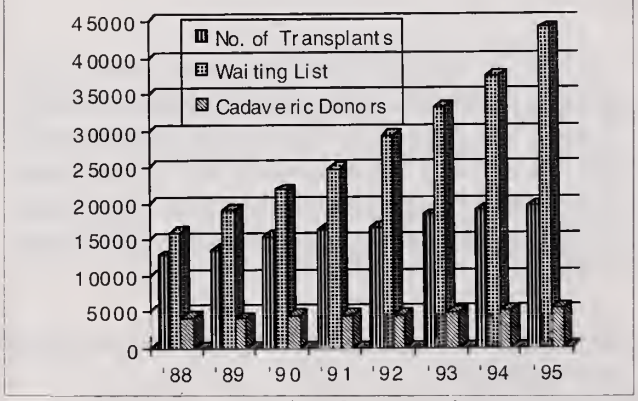
TABLE 1: CADAVERIC TRANSPLANT SURVIVAL RATES 1988-1993

	Grafts (n)	Patients (n)	One Year Survival Graft %	One Year Survival Patient %	Two Year Survival Graft %	Two Year Survival Patient %	Three Year Survival Graft %	Three Year Survival Patient %
Kidney	47,010	47,033	80.6	93.3	74 8	90.4	69.0	87.4
Liver	16,370	16,370	69.1	79.2	64.4	75.4	61.1	72.7
Pancreas	3084	3084	72.0	90.4	66.9	86.8	61.6	83.3
Heart	12,421	12,421	81.4	82.3	76.9	78.1	72.9	74.4
Lung	1936	1936	70.0	71.6	60.4	63.3	52.7	55.8
Heart-Lung	360	360	60.5	60.8	52.4	52.9	48.1	48.9

United States; in December 1995, this list had grown to forty-four thousand and fifty-seven individuals, most between the ages of 18 and 49 years.

Unfortunately, the number of solid organ donors and organs available for transplantation did not grow proportionately across this same time period. Four thousand eighty three donors were recorded in 1988, with an increase to only 5357 donors in 1995, despite approximately 15,000 brain-dead potential donors each year (Figure 1).

FIGURE 1: RECIPIENTS WAITING AND TRANSPLANTED -VS- DONORS, 1988-1995



Advances over the last few years in procurement surgical techniques and organ preservation technology have resulted in an increase in organs recovered and transplanted per donor. Nationally, 3.7 organs were recovered per donor in 1995, with 3.6 organs per donor actually transplanted. The introduction of improved preservation solutions has made transportation and sharing of organs across the United States a viable option. Kidneys can now be transplanted up to 60 hours post recovery. Liver and pancreas transplantation can be successful after up to 12 hours of donor organ cold storage. Heart and lung tissue remains very susceptible to ischemia; these organs generally need to be reperfused within 4 to 6 hours of removal from the donor. Despite the modest increase in total donors and the increase in totalorgans recovered, the demand for transplantable organs continues to far outstrip the supply. It is estimated that nine patients on the national transplant recipient waiting list die each day because life-saving organs are not available.

In an effort to meet the dramatic need, the transplant community is increasingly looking for ways to expand the pool of available organs. Potential kidney transplant recipients are encouraged to search within their families for possible living related donors. Recently, experimental work has been done exploring the use of living related donors for liver and lung transplantation as well. Unfortunately, many processes which lead to end-stage organ disease (i.e. hypertension, diabetes mellitus) are prevalent within families. Most wait-listed organ recipients will be unable to identify an acceptable potential living related donor. Outcome data on spousal transplants and other living "unrelated" donors has provided support to encourage transplant programs to consider this non-traditional donor pool, but unrelated living donation remains fraught with ethical considerations. Thus, these patients remain dependent upon the medical community and the general population to provide cadaveric organs for transplantation.

A Case

On August 16, 1994, the Mississippi Organ Recovery Agency (MORA) received a call from a primary care physician at a moderate sized community hospital. With the disclaimer "I know this is ridiculous", he described an obese, moderately hypertensive, 72 year old patient he had followed in his private practice for several years who had been brought to the emergency department unresponsive by family members the previous day. CT head scans revealed a massive intracranial bleed. The patient subsequently suffered a respiratory arrest and was intubated and ventilated. Neurological evaluation that morning had been consistent with brain death, and a radionuclide perfusion scan was confirmatory, revealing no evidence of intra-cranial blood flow. The patient's legal next of kin, a son and daughter, when told of their mother's death, had insisted the physician call the organ recovery agency, and requested that the patient be evaluated as a potential organ donor.

The physician was dubious when agency personnel expressed interest, but agreed to leave the patient on the ventilator until the agency could talk with the family, obtain consent, and make some attempts to place organs for transplantation. In the ensuing eight hours, following UNOS standard placement protocols, a critically ill liver

recipient was identified in Chicago, and a California transplant program asked that MORA recover the kidneys for transplantation at their program in an "older donor - older recipient" experimental protocol (presuming renal biopsy revealed reasonably viable glomeruli.)

Operative recovery was successful; the body was released to the morgue. In follow-up conference with the family, they expressed satisfaction that lives had been saved even at the time of their loss. In follow-up conference with the physician, he expressed astonishment that this elderly patient with long-standing co-morbid conditions had been an acceptable donor candidate. All three organ recipients are doing well over one year post transplant.

In the last five years, most of the traditional rules related to acceptability of cadaveric donors have been abolished. In 1996, only Human Immunodeficiency Virus (HIV) positivity, and active malignancy or surgical resection of malignancy (excluding minor skin cancer) within the last five years, absolutely exclude an individual from serving as an organ donor. Although it is unusual for hearts to be usable from donors over the age of 65, livers and kidneys have been transplanted successfully from donors up to the age of 87, if tissue biopsy reveals healthy organs. Hearts and kidneys from hepatitis B and hepatitis C positive donors are routinely transplanted at centers with numerous critically ill recipients and at centers involved in experimental protocols with hepatitis positive recipients.

Recent incorporation of the Centers for Disease Control (CDC) Guidelines for Prevention of HIV transmission into the Federal Register has made it difficult for kidney transplant programs to use organs from donors with even marginally questionable social histories. Most heart and liver transplant programs, weighing the life-saving nature of their procedures, continue to use organs from so-called "marginal" donors with careful and well-documented recipient and family informed consent if the benefit of organ utilization clearly surpasses the risk of disease transmission. With the ever increasing gulf between organ demand and supply, the procurement and transplant communities will almost certainly continue to utilize every reasonable and willing potential donor.

The Law

As in most areas of medicine, the federal government has taken an increasingly active role in transplantation and organ procurement over the last several years. Early legislation in 1968 established the medico-legal basis for declaration of brain death and legality of organ donation, but not until the 1980's did the government recognize that regulations were needed to solidify transplantation efforts in the United States. The National Organ Transplant Act of 1984 (reauthorized and expanded in 1987, 1988, and 1990) established a Task Force on Organ Procurement and Transplantation which resulted in the development of the Organ Procurement and Transplantation Network (OPTN) operated since October 1986 by the United Network for Organ Sharing (UNOS). This legislation also makes it a federal crime to buy or sell organs for human transplantation in the United States. The Omnibus Budget Reconciliation Act of 1985 mandates transplant programs and organ procurement agencies be members of the OPTN and meet certain performance criteria. This legislation also includes provisions for hospital participation in Medicare reimbursement requiring all hospitals routinely ask families of potential donors for organ donation in appropriate cases.

Government interest in transplantation is at least in part financially motivated. Successful kidney transplantation results in a significant Medicare cost savings when compared to the per annum cost of maintaining a patient on chronic dialytic therapy. Currently, all patients entered in the end-stage renal disease program must be considered for transplantation at time of entry. A transplant program representative must document patients which are not considered reasonable transplant candidates.

Likewise, chronic care of liver failure and heart failure patients is a significant drain on Medicare resources with transplantation often resulting in major rehabilitation and return to a productive contributing role in society for these patients. Government involvement in this area of medicine will almost certainly increase in future health care legislation.

Recently, transplant programs and organ procurement organizations (OPOs) have come under increasing government scrutiny as public education efforts have failed to dramatically increase organ donation as expected. It is anticipated the Health Care Financing Administration (HCFA) will be placing additional pressure on hospitals to comply with routine referral laws and to allow procurement agencies to perform death record reviews in an effort to better define true US donor potential. Thirteen of the sixty-five federally certified OPOs did not meet performance criteria in 1996. All but three of these thirteen were granted exceptions to the criteria on the basis of precisely defined extenuating circumstances.

Procurement programs not meeting performance standards in 1998 will almost certainly be discontinued during the next recertification period.

The Problem

Despite over 250 Mississippi citizens currently awaiting organ transplantation, Mississippi has historically had one of the lowest organ donation rates in the United States. The UNOS data base reveals a 1994-1995 average Mississippi donor rate of 10.8 per million population increased from 5 donors per million population in 1992. This compares to a national average of 20 donors per million population. Only Puerto Rico has a consistently lower donor rate than Mississippi! The 1995 Mississippi consent rate on recognized and referred potential donors is 49%, comparable to the national average of 50%. This suggests that culpability for Mississippi's low rate of donation does not lie with the general public but with the physicians and health professionals of the state. As organs from Mississippi donors are first allocated to recipients waiting within the state of Mississippi, this failure to identify and refer potential donors primarily impacts Mississippians with end-stage organ disease. Unfortunately, Mississippi also has one of the highest rates of hypertensive renal and heart disease in the United States.

Although a family consent rate of 50% leaves much room for improvement, a 90% consent rate would not place MORA activity at current national standards. If Mississippi hopes to reach national rates of organ donation over the next eighteen months, health professionals across the state must commit to recognizing the need, refer potential donors, and offer all patients and families the option of organ and tissue donation. Death record reviews over the last six months at several of the major hospitals in the state suggest in at least 50% of patients declared brain dead, families are never offered the option of donation and are not referred to the OPO. Many patients who clinically meet brain death criteria are not recognized as potential donors, and are never actually formally pronounced, particularly in areas of our state without available neurologist and neurosurgical consultative support.

The Solutions

Recognizing the need for aggressive health professional and public education programs as well as an agency dedicated to serving the needs of all the hospitals and physicians of the state, the Mississippi Organ Recovery Agency (MORA), an independent non-profit corporation was established and federally designated on July 1, 1994 as the only organ procurement organization for the state of Mississippi (minus Desoto county which is included in the Memphis metropolitan statistical area). Previously, organ recovery in Mississippi, consistent with historical development of organ procurement nationally, had been part of the transplant programs of the University of Mississippi Medical Center. Over the last ten years, most organ recovery agencies across the country have transitioned into independent, non-profit organizations to better provide services to all hospitals within their designated areas. Independent organ procurement agencies continue to work closely with transplant centers but are able to serve more effectively as liaisons with the donor community from an autonomous position governed by a board of directors with broad, statewide representation. We anticipate the new agency will be able to spearhead growth and development of organ donation within the state via a two-phased educational effort: one facet geared to health professionals and the other to the general public. MORA qualified as a "new" OPO and was thus exempted from HCFA performance criteria for the 1996 redesignation period. The agency will need to approach the national average in numbers of organ donors by 1998, however, to assure recertification and continued equitable availability of organs for Mississippi recipients.

It is the responsibility of MORA to provide education, to approach families with the option of organ donation when consulted, to evaluate and medically manage all referred potential donors once death has been declared, and to coordinate organ recovery and distribution in accordance with federal and UNOS regulations. A single phone call notifying the agency (1-800-362-6169) of the brain-dead patient transfers the obligation to MORA. Many hospitals have designated "requestors" , trained nurses, social workers, chaplains, or volunteers, who are well-versed in issues of donation (Table 2) and are comfortable approaching families with this very sensitive issue after the physician has notified family of the patient's death. Some physicians prefer to discuss the options personally with the patient's next-of-kin. MORA agency personnel are well-trained in family interactive skills and are always willing to come immediately to a hospital to meet with a family to discuss consent for organ donation. Referral of the potential organ donor should never be inconvenient for the referring physician or hospital.

TABLE 2: ANSWERS TO COMMON DONOR FAMILY QUESTIONS

- Brain death is irreversible and medico-legally equivalent to cardiac death
- Which organs and tissues will be eligible for donation and transplantation depends upon the specific co-morbid medical conditions of the donor
- Organ recovery is a careful, sterile operative procedure performed by qualified surgeons which in no way disfigures the body
- Organ donation does not preclude an open casket funeral
- There is never any financial cost to the donor family
- All major organized religous groups on the United States support the option of organ donation
- Donor and recipient confidentiality is always respected, however donor families will be provided basic information about the outcome of the donation

Mississippi is infamous for being "last" and "worst" in the nation in many domains including such areas as obesity, illiteracy, and homicides. Health professionals as a single group can not move Mississippi out of the basement in any of these areas. Mississippi is also last in the nation in organ donation. This is one statistic health professionals, particularly physicians, can change. The Mississippi Organ Recovery Agency is a valuable resource for all hospitals, health professionals, and citizens of the state, but if not utilized this resource will disappear in 1998. Physicians are encouraged to notify the agency of all situations of impending or declared brain death. No matter how unlikely the donor, how dramatic the co-morbid donor conditions, if the family is willing, MORA will attempt to place organs for transplantation. Somewhere, someone's life may be saved; it will probably be someone right here in Mississippi.❑

REFERENCES

Contact the Author.

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Physicians' Recognition Award



Twenty-one MSMA members were named recipients of the AMA Physicians Recognition Award in June 1996, six in February. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
James Nello Martin, MD
Paul Eugene Sheffield, MD
Catherine Ann Thompson, MD

Clarksdale and Six Counties Medical Society
Frank T. Marascalco, MD

Coast Counties Medical Society
Craig Martin Slater, MD

Desoto County Medical Society
Malcom Davis Baxter, MD

East Mississippi Medical Society
Cheryl Gay Clark, MD
John Stephen Harris, MD
Walter Lewis Willis, MD

Northeast Mississippi Medical Society
Robert Eugene Coghlan, MD
Richard Shelton Hollis, MD
Mark Jackson Kellum, MD

Prairie Medical Society
Robert Keith Collins, MD

Singing River Medical Society
Michael D. Horowitz, MD

South Central Medical Society
Richard Gerald Burris, MD
Elmo Pierce Gabbert, MD
William Bruick Larkin, MD
Terry Earl Westbrook, MD

South Mississippi Medical Society
Richard Alan Johnson, MD
Lisa Clark Bushardt, MD
Anne Milia Stefani, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

J. Edward Hill, M.D. Elected AMA Trustee

During the American Medical Association's (AMA) Annual Meeting Dr. J. Edward Hill became the first Mississippian elected to the distinguished AMA Board of Trustees. He will serve a three-year-term, 1996-1999. A board-certified family physician for 26-years in the rural Mississippi Delta, Dr. Hill practices medicine in Tupelo where he is Director of the University of Mississippi Family Practice Residency Program at North Mississippi Medical Center.

A veteran of organized medicine activities, Dr. Hill has served as an AMA Delegate for the Mississippi State Medical Association since 1984, Alternate Delegate 1976 to 1983. Until his election to the AMA Board he served as vice-chair of the AMA Council on Legislation of which he had been a member since 1990. He has also represented the AMA in testifying before Congressional committees and federal agencies on the subject of rural health care delivery.

Dr. Hill is a past president and chairman of the board of the Mississippi State Medical Association. A graduate of the University of Mississippi School of Medicine, Dr. Hill has been actively involved with the American Academy of Family Physicians. A dedicated clinician, he is Medical Director of a physician directed primary care network covering 22 counties in northeast Mississippi. He was named "Mississippi Family Doctor of the Year" in 1991 by the Mississippi Academy of Family Physicians of which he was president in 1980. In 1977 he was Good Housekeeping magazine's "Family Doctor of the Year," runner-up.

A community leader, Dr. Hill was a gubernatorial appointee to three statewide health care advisory committees. He has served as Chairman of the State Public School Health Education Curriculum Committee, President of the Mississippi Chapter of the American Heart Association and on the Board of Directors of the University of Mississippi Medical School Alumni Association. Dr. Hill has Chaired the Industrial Development Committee for his local Chamber of Commerce, been President of his local School Board, has served on the advisory board for his county Head Start program and his church board of directors.



Dr. and Mrs. J. Edward Hill

Dr. Hill grew up in Vicksburg, Mississippi, the son of the Mr. and Mrs. Frank S. Hill. Dr. Hill's wife, the former Jean Ware of Clinton, is a past president of the AMA Alliance. They have two daughters, Ginger and Katherine.❑

J. Edward Hill, M.D.

The AMA's New Trustee Talks About His Vision for Organized Medicine



Photo by: Ed Darling

Tell us first something about yourself. How and why did you get involved in medical organization activities?

I left medical school and internship and entered private practice with a feeling that there was a strong bond of understanding and collegiality that existed among and between physicians. That was based on a desire for getting to the truth both medically and socially. As trite as it may sound, I had a desire to make a difference and contribute to patients' general well being and healing.

My first real introduction to organized medicine as a means of communicating with the profession and the public came about during a rural health conference that was held by the Governor in Mississippi back in 1977. I was asked to give a talk on why there was a shortage of physicians in rural Mississippi. Organized medicine through the State Medical Association asked me to give that presentation and that was my introduction to organized medicine's input into public policy. That same day I was also introduced for the first time to politics. I was introduced by the Governor of the state of Mississippi (a man who I had never seen in my life much less shaken hands with or become friendly with) as his long time and good friend. Right away I knew I was in for an interesting time dealing with politicians. I also felt, and still do, that organized medicine can truly be the real advocate for the average patient, who I believe has no real advocate in our society. Some politicians, of course, and government programs call themselves advocates, but they do it for reasons that often are not ideal or based on less than pure motives. Unfortunately, they are most often based on political needs of those in that realm of public service.

What are some of your first impressions as an AMA Board member of both the organization and its goals?

I believe the thing I was struck with the most, initially, is the superb quality and professionalism of those who staff the AMA Board and Officers. I hope that my impression and my feelings about the organization, that is the AMA and its goals, will not change just because I am viewing it from another vantage point, (i.e.



Board of Trustees). The goals of the AMA continue to be extremely challenging but not insurmountable. I do think that the board has to be the catalyst that narrows the focus of the organization so that it can successfully meet the challenges, both in the legislative arena and in the public advocacy and policy arena.

What do you see as the role of an AMA Trustee?

I believe a Trustee must be one who will listen carefully and intently, will be a fast learner, and will be a consensus builder. I also believe a Trustee must be an innovator of ideas and have the ability to do futuristic thinking but develop realistic policy that is driven always with an eye on the ideal. Fiscal management and integrity will have to be of utmost importance to an AMA Trustee.

What do you think should be the top priorities of the AMA, recognizing that it can't do all things at all times?

The first and most important priority of the AMA should be to unify physicians in this country and I might note that my whole campaign for AMA Trustee was run on this theme. It is only with this unity and this increased involvement that we will be able to accomplish our vital priorities which are, protection of patients from the possible perils that could be involved in the changing financing and delivery system of health care. A top priority must continue to be, as it always has been, to protect the educational system and the research institution of American medicine. I believe a third priority should be a redoubling of our efforts for the protection of the public health in conjunction with the very strong and somewhat idealistic public health organizations in the country. Hopefully this effort can be achieved in close cooperation and collaboration with those organizations. I think this has to include the physical and mental health of the public. And lastly, I think the organization must protect physicians from those who would try to destroy the patient/physician relationship by changing systems of care and financing of care. If you look at these few priorities I've mentioned, everyone of them has to do with being involved in the legislative process both on a local, state and national level.

Anti-trust relief and tort reform are legislative issues of great concern to Mississippi physicians. What priority does AMA place on these issues?

The AMA places these at the top of its legislative agenda and will continue to push vigorously and tenaciously for anti-trust relief in the form of legislation or court action and will continue also to promote medical tort reform. I believe if you look at the history of our organization you'll find that its persistence has been responsible for our successes in the past in the legislative arena. We must continue to work on this without letting up.

The public image of physicians seems to have diminished. What is AMA doing to improve the image of MD's?

If the image of physicians is diminished - and I doubt that it is very much diminished- those reasons would be related to the unbelievable advances in technology, the explosion in knowledge that is taking place on a daily basis, and the fact that we may be victims of our own successes. The life expectancy of course has continued to go up and this is driving up cost due to changes in delivering health services. The fact that the management of cost is trying to take the place of the management of patient care and getting between the doctor and patient is the cause of our image problems. We are seeing non-physicians and business people often making medical decisions. The patient often does not realize these decisions are made by non-physicians. This creates a problem with the public's perception of physicians.

But the AMA continues to help improve the perception of its members by continuing to promote public health issues like tobacco cessation and reducing violence. I believe we will continue to try to have physicians much more involved in public education and community education. The AMA will continue to advocate and demand educational excellence in our training programs and will fight for proper funding for research. I think the AMA will continue to promote optimism among physicians in this country and restimulate their devotion and passion for medicine. I think the AMA must be the catalyst to bring physicians who feel badly about the profession to the table so that we can deal with their problems, their anxieties, and their fears in a very positive manner. I also think the AMA must convince physicians that we cannot buy an image, that it must be a very individualistic thing. The average physician has a special calling to this profession. It must be reinforced. We must convince physicians that only by losing their self-image will their image with the public be diminished.

The AMA, State Medical Associations, County Medical Societies and Specialty Societies all represent physicians but not all physicians are members of each. How do you see all of these physician organizations working together?

The AMA has constantly been changing since its inconception. I just completed reading a very good history of American health care policy and the



AMA since 1940. This book (*American Health Care Policy Since 1940*) should be in every physician's library. It demonstrates the enormous numbers of changes that have been occurring in the AMA in the last 50 years or so. It proves that the AMA is an extremely dynamic organization. All the changes in medicine (i.e. the changes in the delivery system, the changes in financing, the changes in numbers, quality and quantity of specialists) have all had a significant impact on the AMA. The AMA has recognized this and about two and one-half years ago began working on a complete overhaul and restructuring of representation in the entire federation of medicine. I speak of county medical societies, state medical associations and specialty societies. The idea was to increase physician input and change the way the American Medical Association makes policy so that physicians in all aspects of medicine would feel a part of the solution to problems. Getting all these specialty societies and county medical societies, and state medical associations to work together with unity of purpose will be a great challenge but is certainly doable. The AMA is also involved in a project to look at the value of membership. We must communicate in a different, better, and more successful way with everyone from the grassroots small town solo practitioner to the large group practice physician and to the managed care physician. If you look at the history of the American Medical Association over the past 30, 40, or 50 years you will see that it will be able to accomplish these very, very difficult tasks. It will not be without significant debate, it will not be without enormous change and it will not come about without the collaborative efforts of all the players. It reminds me of a sign on a marquee that I saw out in the front of an abandoned church in Memphis, Tennessee that had been turned into a rug store. The marquee said *"Only change endures."*

I believe the AMA knows that change is absolutely essential, that we must increase our membership in every aspect of the federation, that we must present ourselves to the public with a common voice and hopefully common actions, and that we must become much more operationally efficient and productive and thus become more cost effective. We must all work hard in a collaborative way if we are

to achieve success. I hope and feel sure that the American Medical Association will continue to do these things-with the goal in mind of advocating on behalf of patients first and physicians second.

How will physicians in our state benefit from representation by you on the AMA board?

I think my election will give them a sense of ownership to policy making by the AMA. Hopefully, it will let them know that even a small town doctor from a small state can have significant input in national medical policy decisions and in changing things for the better. I hope it also will stimulate physicians in our state to come forth with innovative solutions to problems and to realize that they can have a real impact and voice in decisions that are made. I want to be able to take grassroots problems from our patients and physicians and let them "trickle up" to the higher levels of policy making in the American Medical Association.

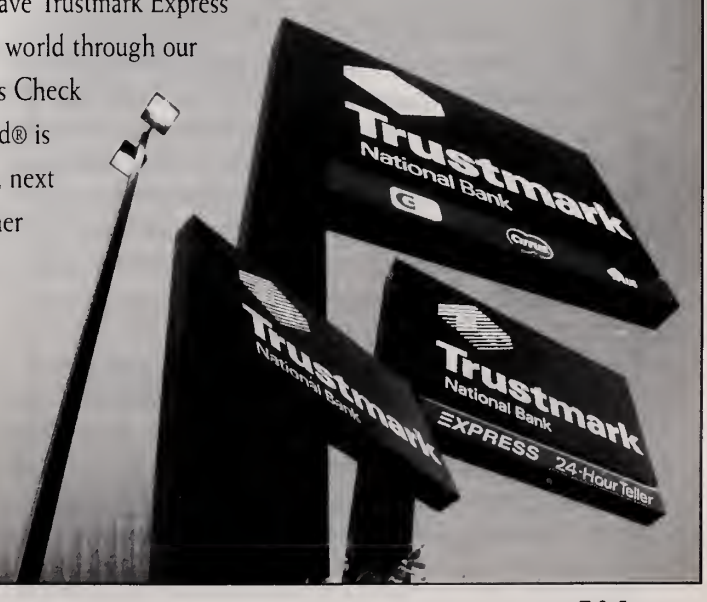
In closing, I hope and pray that I will not lose my vision concerning what is best for patients first. And, I also hope and pray that we as physicians will not let our professional morality and idealism drift or be pulled from its moral center. I pray we will never lose sight of the fact that when the examining room door is closed, the patient/physician relationship is the only thing that matters.❑

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AMA Resolution 425 Mandates HIV Testing and Counseling of all Pregnant Women

Relying heavily on statistics showing that treating HIV-positive women during pregnancy reduces by two-thirds their risk of infecting unborn children, the American Medical Association endorsed mandatory testing and appropriate counseling of all pregnant women and newborns for HIV.

HIV Screening and Treatment in Pregnancy

Elaine L. Ross, M.D.

Women infected with the human immunodeficiency virus (HIV) account for the rapid rise in cases of acquired irnmunodeficiency syndrome (AIDS) over the past decade. As the incidence of HIV infection has risen among women of childbearing age, an increasing number of children have become infected through perinatal transmission. It has been estimated that approximately 7000 children yearly are born to HIV infected women. Given a perinatal transmission rate of 15-30%, an estimated 1000-2000 HIV infected infants are born annually. Ten to 20% of perinatally infected children will develop rapidly progressive disease and die by 24 months of age.

HIV counseling and testing for women offer important disease prevention opportunities for women and their infants. Interventions designed to reduce morbidity in HIV infected women require early diagnosis so that treatment can be initiated prior to the onset of opportunistic infections. For infected women, knowledge of their HIV status provides opportunities to obtain early treatment for themselves and to make informed reproductive decisions so that the risk of perinatal transmission might be reduced through anti-retroviral therapy.

Previous national guidelines regarding HIV have recommended testing women known to have significant risk factors for HIV exposure such as intravenous drug use or sexual relations with partners infected with HIV. Subsequent studies have shown that by only offering testing to those women with high-risk behaviors, as many as 50% of infected women will not be identified. Accordingly, the U.S. Public Health Service strongly urges health care providers to ensure that all pregnant women are counseled on HIV transmission and are encouraged to

be tested for HIV infection. Both pretest and posttest counseling should be provided. Counseling should include information regarding the risk of HIV infection associated with sexual activity and intravenous drug use and the risk of perinatal transmission as well as the availability of therapy to reduce these risks. Uninfected pregnant women who continue to practice high-risk behaviors should be counseled to avoid continued exposure to HIV and to be retested in the third trimester.

Several maternal factors have been associated with an increased risk of perinatal transmission of HIV disease including a high viral load, low CD4 count, advanced HIV disease, and presence of p24 antigen. Intrapartum events resulting in an increased exposure of the fetus to maternal body fluids. such as prolonged rupture of membranes, increase transmission rate as do premature delivery and breastfeeding. Factors associated with a decreased rate of transmission include cesarean section and the presence of maternal neutralizing antibodies. Of the factors associated with a decrease in perinatal transmit sign' the most promising is maternal therapy with the antiretroviral drug zidovudine (azidothymide, AZT).

All HIV infected pregnant women should be counseled on the benefits and risks of zidovudine therapy. Results from a multicenter, placebo controlled clinical trial indicated that administration of zidovudine toa selected group of HIV infected women during pregnancy and labor and to their newborns within 24 hours of delivery reduced the risk of perinatal transmission by approximately two-thirds. The rate of perinatal infection in the placebo group was 25.5% as compared to 8.3 % in the zidovudine group. The only adverse effect of therapy in treated infants was mild transient anemia which resolved spontaneously.

In summary, HIV testing should be offered to all women as early in pregnancy as possible so that informed and timely reproductive and therapeutic decisions can be made. Such testing will better insure that women can look forward to delivering healthier babies.

Dr. Elaine L. Ross is a Fellow, Maternal-Fetal Medicine, at the University of Mississippi Medical Center.

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Guidelines for Management of the HIV Infected Pregnant Woman

First trimester or first prenatal visit
Confirm HIV status.
Discuss the following:
perinatal transmission rate
possible decreased fetal transmission with zidovudine therapy pregnancy
termination permanent sterilization safe sex practices.
Monitor for opportunistic infections.
Labs: prenatal panel including CBC, CD4 counts. renal and liver panels, hepatitis panel, pap smear, gonorrhea, chlamydia, syphilis, TB skin test if history is negative.
Ultrasound for gestational age.
Vaccinations: hepatitis B. pneumococcal and influenza.
Medications: prenatal vitamins with folic acid, iron supplements, zidovudine 100 mg po five times a day if hemoglobin > 8 and granulocytes > 750.

Second Trimester
Perform routine prenatal care.
Monitor for opportunistic infections.
Repeat CD4 count, CBC, and RPR.
Ultrasound for fetal growth in late second trimester.

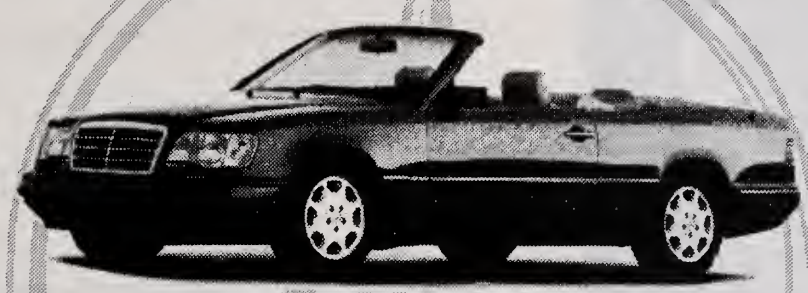
Third Trimester
Perform routine prenatal care.
Monitor fur opportunistic infections.
Repeat CD4 count, CBC, RPR, and liver panel.
Serial ultrasound for growth every 4 weeks.

Intrapartum
Routine intrapartum care and universal precautions.
Avoid fetal scalp electrodes, amniocentesis, and amniotomy.
Repeat CD4 count, CBC, RPR, and liver panel.
Zidovudine 2 mg/kg IV loading dose given over 1 hour then 1 mg/kg/hour continuous IV infusion until delivery.

Postpartum
Routine postpartum care.
Blood and body fluid precautions.
Breastfeeding is contraindicated.
Discuss contraception options.
Arrange for long-term follow-up.
Discontinue zidovudine if CD4 count is > 500 otherwise continue zidovudine 100 mg po 5 times a day.
If CD4 count < 200 begin Bactrim DS, 1 tablet 3 times a week, for *Pneumocystis carinii* prophylaxis.
If CD4 count < 75 begin Rifabutin 300 mg/day for prophylaxis against disseminated infection with *Mycobacte- rium avium* complex.
If CD4 count < 50 begin fluconazole 100-200 mg/day for cryptococcal prophylaxis.

Neonate
Zidovudine 2 mg/kg every 6 hours beginning as soon as possible after birth preferably within the first 8 hours and continuing for 6 weeks.
Obtain CBC with differential.
Prior to discharge home, make sure that the mother has a supply of zidovudine and knows how to administer it properly.
If possible, arrange for home health agency to visit infant at 1, 3, and 5 weeks to evaluate and encourage compliance.
Evaluate at 3 weeks for weight adjustment of zidovudine dosage, CBC, p24 by PCR.
Begin Bactrim 5 mg/kg at 1 month of age anti continue until the infant is determined to be not infected.
Follow-up examination at 6 weeks.

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Fred L. McMillan, M.D.

The President's Page

More on Unity

Your membership in organized Medicine has never been more important....important for your colleagues, your patients, and yourself. We must have professional unity on a Community level, the State level, and National level.

With health care being paid for mainly by business and government, one physician's gain may be another's loss. The potential for fragmentation has never been greater. We may feel like "We are all in this alone"; but, this is not the case. When physicians have a problem, organized Medicine has led the way to solving that problem with individual members voicing their opinion, deciding on a course of action, and then holding to that course.

Working together as a profession is vital to our success. We may not always agree on everything, but, just as we don't apply a litmus test to our churches or our families, we should be careful not to make that mistake with our professional organizations. Together we can move forward. For our profession and for our patients, we need your support and participation.

Our profession has had a wealth of respect and opportunity deposited in it by those who have come before us. Each physician has benefited and needs to continue this tradition. We need to be sure to add more to our profession than we withdraw.

Fred

Editorial

JOURNAL OF THE
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OLD DAN TUCKER SYNDROME

"As to pain, I am almost ready to say that the physician who has not felt it is imperfectly educated."
- Dr. S. Weir Mitchell, 1829-1914

As a fresh and totally healthy physician of 25, I gave little import to many of the ailments middle-aged women complained of... minor arthritis, insomnia, anxiety, vague pelvic complaints, and the one I could least identify with at that stage in my life, premenstrual syndrome. I remember now, with some regret, the numerous times I would go back to my desk to write-up their charts and chuckle to myself that the woman back in the exam room was "just a whiny wimp who couldn't handle a little pain."

I remember the mini-lectures I would dispense about the virtue of overlooking minor discomforts and not blowing them out of proportion. I remember women prefacing the discussion of their symptoms with me by saying, "I chose to come to you because you are a woman and I know you would understand." But, I really didn't. Not at the time.

With some of these ailments the Lord has richly blessed me now, hopefully not as punishment for thinking others neurotic, but so as to complete my education as a physician. Those who never feel pain seldom think that it is felt.

For any reader who is skeptical about PMS let me assure you that it is quite a real and worrisome beast, not the often-ridiculed pseudo-illness that many tout it to be. I didn't get the full education on this subject until around age 35 when at certain times each month I could feel myself becoming a sort-of Jekyll and Hyde personality, managing somehow to sublimate during the day as the smiling and all-knowing Dr. Jekyll and unleashing the Ms. Hyde entity when I got home at night. There were times when it actually seemed I could feel the "rest of me" on the inside reeling in disbelief that those terrible rantings were actually coming out of my mouth.

From this phase of my medical education, the "life-experience seminar" as it were, I am not the authority on the subject that my female patients have believed me to be for the past 15 years. Mind you, I'm still not totally convinced of the existence of Chronic Fatigue Syndrome, but I'll keep my thoughts to myself on that one. I'd much rather skip that course.

I'm sorry that you male physicians will only get to experience the PMS phenomenon vicariously as your wives approach the pre-menopausal stage of life.

"A man may sympathize with a woman in childbearing, though it is impossible that he should conceive himself suffering her pains in his own proper person and character."
-Adam Smith (1723-1790) from "the Theory of Moral Sentiments"

Do not gather that I am implying that men are inadequate to care for women's ailments because they have not experienced them firsthand . . . no more than I would ever suggest that I am somehow less able to treat prostatitis or erectile dysfunction because I've never had them.

Thankfully most all the male physicians I've been to in my life were either born with or acquired a great deal of kindness and understanding along the line which supplemented the clinical competence they had gained in med school.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

The quality we seek for both male and female physicians here is empathy. And true empathy requires both "the knowing and the living."

Then, too, the chronological age of a physician comes into play here, doesn't it? The ideally educated physician, the one who has lived long enough to experience so many other human maladies that befall us, would no doubt be too feeble to practice. Looking back, I suppose we managed as young physicians simply because we possessed vast expanses of energy then, and we cared a great deal, even though we had not felt true illness or great pain.

Forty packs a wallop. My sister, who is twenty years my senior, warned me long ago that once you hit 40 there is a new ache or pain each week. She was right. It's a kind of Chinese torture, wondering what will be my next "Grunt of the Week."

Two weeks ago I had a bout of plantar fasciitis in my left foot. For days it felt like I was impaled on a railroad spike as I pounded the concrete slab at the office. Mornings were the worst! I renamed this particular connective tissue disorder "Old Dan Tucker Syndrome" and had a laugh with every patient who asked about my limp. You remember "Old Dan Tucker" from the childhood song, don't you? He was that fine old man who washed his face in a frying pan, combed his hair with a wagon wheel and died with a toothache in his heel.

I don't expect to die from it, but it sure as heck is killing me.

It is kind of sad how most of us don't get serious about our health until we lose it. You've experienced the hypertensive who won't take his meds or get his blood pressure checked until after his first stroke, and the diabetic who refuses to be compliant until he becomes impotent. We are no better than they.

Marcel Proust said, "Illness is the Doctor to whom we pay most heed: to kindness, to knowledge we make only promise, it is pain that we obey. "

Indeed pain is a great motivator. I never wanted to lose weight any more than when I was stricken with "Old Dan Tucker Syndrome." The Catch-22 of it is that once you start limping like Chester on "Gunsmoke" aerobic exercise becomes nigh on to impossible. Then, the NSAIDS you prescribe for yourself set your belly on fire and you have to eat to buffer them. (At least that's how I rationalized eating at the time.)

Dr. Dan Edney asked me to join the Young Physician's Section of the MSMA the other day. He looked at me quizzically after about three minutes of uncontrolled laughter on my part and said, "What is wrong with you, girl?" I explained that I was quite flattered that he thought I was a girl and under forty to boot. I am neither a novice in space or time.

God, am I really halfway "there"? Yes, and slowly coming to terms with it, thank you. Turning forty is a major milestone. I was nauseated that entire day. Perhaps receiving no less than three dozen black balloons with the Grim Reaper on them, dead flowers, a set of false teeth, and a birthday cake shaped like a tombstone had something to do with it. I am now of the opinion and unashamedly so, that every thinking person will have at least some degree of a "mid-life crisis." (Another rationalization?)

A final word to physicians, take care of yourself or you won't be around long enough to take care of anyone else. And remember that we are all patients sooner or later and will become wiser doctors for having been one.

Dwalia South, M.D.
Editor

Horizons Flu Project Underway

Influenza vaccination is not a new health care quality improvement project at the Foundation nor is it a new subject in this column. Since 1994, this clinical improvement project directed at increasing the percentage of eligible Medicare beneficiaries immunized against influenza has attracted a number of provider collaborators from throughout the state.

The Foundation's influenza project has included a unique emphasis on immunization of hospitalized patients. Studies have shown that 40 percent of elderly patients hospitalized with influenza-associated respiratory conditions had been hospitalized during the previous vaccination season but did not receive the influenza vaccine before discharge.

The project is continuing in an effort to increase the number of vaccinations and decrease the problems of influenza in the state. But a different focus will occur this year through the Horizons Project, a 22-month cooperative effort between the Foundation and the Mississippi Urban Research Center (MURC) of Jackson State University. MURC Acting Director Dr. Felix A. Okojie, who also is assistant vice president for research and development, and his staff, are working with the Foundation staff on this special project aimed at African-American Medicare beneficiaries, only 17.3 percent of whom received a flu shot in the 1993 flu season. This national statistic compares to 36.5 percent of Caucasian beneficiaries who received the flu shot.

The rate for African-American beneficiaries increased by a 2.5 percentage point in 1994 but was still half the rate for Caucasians, according to Health Care Financing Administration statistics.

Similar trends have occurred in Mississippi. In the 1993 season, only 15.5 percent of African-American Medicare beneficiaries received a billed flu shot in Mississippi; in that same year, 26.6 percent of Caucasian beneficiaries received the shot. The rate for African-American beneficiaies increased to 20.3 percent in 1994 and 20.9 percent in 1995, compared to 45.8 percent of Caucasian beneficiaries who received the flu shot.

Among African-American beneficiaries, the available data show that in 1994 the billed influenza immunization rate for women was 21.7 percent compared to 18.1 percent for men.

These data clearly show a need to increase the overall immunization rate for Medicare beneficiaries and a systematic approach in the design and implementation of health education and promotional, measurable interventions to facilitate health behaviors and informed health care choices by African-American beneficiaries.

Goals of the project are to increase the overall immunization rate for African-American Medicare beneficiaries in Mississippi and to improve the use of preventive services among these beneficiaries.

Objectives include conducting a needs assessment to identify opportunities, barriers and access to participation in flu shots. A pilot project will be utilized in 1996 in six counties.

Building community capacity for self improvement will be sought through a Horizons Advisory Board and partnerships with local community groups and providing a bridge between theory and practice for continuity of the flu campaign.

This campaign will include working with community-based organizations and community leaders; publicizing the program; offering door-to-door education; and making presentations to church and civic groups, health organizations, schools and nursing homes.

A state-specific evaluation plan will determine actual impact of the interventions on the Horizons goals.

Following the 1996 pilot project, planning, implementing and analyzing 1997 statewide interventions will be a collaborative effort between the Urban Center and the Foundation.

Anyone wishing more information on this project can contact Marsha Watson, the Health Care Quality Improvement Program Department manager; Tammy Clark, influenza project manager, or me at 601-354-0304.

-James S. McIlwain, M. D.
Principal Clinical Coordinator



Dr. Susan Chiarito

Tar Wars Gives Youngsters Age-Targeted Info About Tobacco

Family medicine residents and faculty of the University of Mississippi Medical Center (UMC) in Jackson have returned from fifth-grade classrooms in 20 schools in 11 Mississippi towns with a renewed appreciation for phrases like "hurling phlegm" and "zoo breath."

Thirty family medicine residents and faculty and one psychiatrist on staff have presented the "Tar Wars" program aimed at reducing the number of people who start smoking by influencing youngsters at a crucial decision-making time in their development.

Dr. Susan Chiarito, a third-year family medicine resident and Vicksburg resident who enlisted her colleagues in the program, says "fifth-graders love it when you start talking about phlegm. The grosser the better."

Chiarito says she'll continue to work recruiting physicians to talk to classes when her residency ends this July and she enters practice. Dr. Keenan Wilson and Dr. Todd Stokley, second-year family medicine residents, will continue the program on the UMC campus, recruiting residents and staff. Chiarito, Stokley and Wilson attended workshops and came back to organize the program among UMC physicians.

The entire Tar Wars presentation is based on studies which show that children make the decision to start smoking sometime between the fifth and eighth grades. Chiarito sees it as a battle with tobacco companies which have seemingly endless resources (estimated to be $9 million a day) to recruit young smokers through advertising. "If we can influence them early in that period, we think we can undermine the message that tobacco companies use to lure youngsters," Chiarito said.

Tar Wars is an outgrowth of the Doctors Ought to Care (DOC) program, established by family medicine residents

whose goal was to improve public health with campaigns to prevent tobacco use and alcohol abuse. One of the charter members and national leaders in DOC was Dr. Tom Houston, a UMC graduate and a UMC family medicine residency alum.

Tar Wars has a narrower focus both in target and message. "We tell fifth-graders what bad things smoking can do to you now--not what it will do when you're 60," Stokley said. "They don't think in the long-term. Their decision not to smoke will be based on how it will affect them now."

As the presenters have told the classes, smoking gives them 'zoo breath', makes their clothes smell bad, can cause them to "hurl phlegm," costs a lot of money, and can burn holes in their best clothes. Chewing tobacco stains clothes, and "you have to spit."

One of the exercises asks students to compute the cost of smoking over a year's time, and the Tar Wars representative points out what else the money could have bought. Wilson, who had just cashed a payroll check, actually showed his fifth-grade audience how much can be spent on smoking a pack of cigarettes a day for a year. "They were impressed," he said.

Chiarito's ultimate goal is to reach all the fifth graders in Mississippi by asking physicians to do one presentation to one class in a year. "If we can reach one student from each class, we think we will have succeeded," Chiarito said.

"There's really no time involved in preparation. It's all in a package, ready to go. All the physician has to do is lead the classroom in its discussion and in the exercises.

Chiarito's intermediate goal is to hook into the family medicine preceptor network. The department has more than 120 preceptors in towns all across Mississippi each of whom hosts a student in his or her practice for a three-week mandatory block in family medicine. "If the preceptor is too busy to make the presentation, the student can do it easily," Chiarito said.

The students who listen to the Tar Wars talk were asked to create original posters based on what they've learned. The posters are judged, and state winners compete nationally for a trip for four to Disney World. School winners get T-shirts which say "Say no to Cancer Joe."

Cancer Joe bears a resemblance to Joe Camel, the advertising icon one tobacco company uses in its advertising directed to young audiences.

The same T-shirts sell for $12, and proceeds go to the Mississippi Family Health Foundation earmarked for the Tar Wars program. Contributions to Tar Wars also go to the foundation and help pay for Tar Wars speaker packets and items which speakers can give to students.

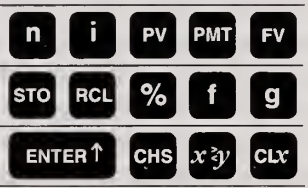
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New Members

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BENNETT, WILLIAM G., Starkville. Born Lucedale, MS, September 21, 1959; MD University of Mississippi School of Medicine School of Medicine, Jackson, MS, 1984; medicine residency, University of Arkansas for Medical Sciences, Little Rock, AR, 1985-87; gastroenterology residency, University of Florida Medical Center, Gainesville, FL 1993-95; elected by Prairie Medical Society.

BLOODWELL, ROBERT D., Natchez. Born Willmington, DE, August 2, 1932; MD Baylor College of Medicine, Houston, TX 1957; fellowship, National Heart of Institute, N.I.H., Bethesada, MD, 1958- 60; general surgery residency, The Johns Hopkins Hospital, Baltimore, MD 1960-65; elected by Homochitto Valley Medical Society.

BRUNER, BILLIE W., Jackson. Born October 13, 1950; MD University of South Alabama Medical School of Medicine, Mobile, AL, 1987; anesthesiology residency, same, 1989-90; elected by Central Medical Society.

BULLOCK, JOHNNY R. JR., Columbia. Born Hattiesburg, MS, October 23, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; internal medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by South MS Medical Society.

CLAY, BRYAN M., Jackson. Born Hinds Co., September 30, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; otolaryngology residency, University Medical Center, Jackson, MS, 1992-96; elected by Central Medical Society.

CRITTENDEN, MARCUS A., Starkville. Born Greenville, MS, June 28, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1993; medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by Northeast MS Medical Society.

DAVEY-SULLIVAN, BARBARA, Jackson. Born Yazoo City, MS, June 4, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1988; ob/gyn residency, University Medical Center, Jackson, MS, 1992-96; elected by Central Medical Society.

GORDON, KYLE F., Jackson. Born New Orleans, LA., March 4, 1964; MD Tulane University School of Medicine, New Orleans, LA., 1991; general surgery internship, University Medical Center, Jackson, MS, 1991-92; otolaryngology, head & neck surgery residency, same, 1992-96; elected by Central Medical Society.

HARRIS, ROBERT LOVE, Jackson. Born Tupelo, MS, September 17, 1963; MD Univeristy of Mississippi School of Medicine, Jackson, MS, 1990; ob-gyn residency, same,1990-94; urogynecology & reconstructive pelvic surgery fellowship, Duke University Medical Center, Durham, North Carolina 1994-96; elected by Central Medical Society.

HILL, CHARLES K., Tupelo. Born Jackson, MS, May 26, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by Northeast MS Medical Society.

HINES, RANDALL STUART, Jackson. Born Bloomington, IN, January 15, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year, University of Kentucky Medical Center, Lexington, KY; ob/gyn residency, same, 1989-92; reproductive endocrinology fellowship, Medical College of Georgia, Augusta, GA., 1992-94; elected by Central Medical Society.

KING, CHARLES M., II, Tupelo. Born Honolulu, HI, May 2, 1964; MD University of Kansas School of Medicine, Kansas City, KS, 1990; medicine residency, University of Oklahoma Medical Center, Tulsa, OK, 1990-93; fellowship in rheumatolgoy, Dartmouth Medical Center, Lebanon, NH 1993-95; elected by Northeast MS Medical Society.

LODEN, JULIAN DALE, Tupelo. Born, Tupelo, MS, July 14, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; medicine residency, University Medical Center, Jackson, MS,

1993-96; elected by Northeast MS Medical Society.

MACK, ROBERT L., III, Jackson. Born Clinton, OK, April 1, 1964; MD University of Arkansas School of Medicine, Little Rock, AR, 1991; radiology residency, Baylor University Medical Center, Dallas, TX, 1991-95; fellowship in body imaging, same, 1995-96; elected by Central Medical Society.

MADNANI, HARISH M., Tylertown. Born Poona, India, September 11, 1955; MD SMS Medical College, Jaipur India 1978; medicine & geriatric residency, St Bartables Medical Center, Livingston,NJ, 1980-84; elected by South Central Medical Society.

MOORE, JAMES L., JR., Jackson. Born Kailua, HI, June 16, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1985; ob/gyn residency, University Medical Center, Jackson, MS, 1989-93; gynecologic oncology fellowship, Georgetown University Medical Center, Washington, DC; elected by Central Medical Society.

PRINGLE, CHARLES, K., JR., Jackson. Born Gulfport, MS, April 15, 1963; MD University of Tennessee School of Medicine, Memphis, TN, 1991; diagnostic radiology residency, same, 1991-95; nuclear medicine fellowship, Washington University-Barnes Hospital, St. Louis, MO, 1995-96; elected by Central Medical Society.

PICKERING, ROBERT M., Southaven. Born Oxford, MS, May 16, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; interned one year, Baptist Memorial Hospital, Memphis, TN; orthopaedic surgery residency, University of Tennessee Medical Center & Campbell Clinic, Memphis, TN, 1992-96; elected by Desoto County Medical Society.

SHEPHERD, MARK D., Tupelo. Born Chateauroux, France, February 7, 1960; MD Emory University School of Medicine, Atlanta, GA, 1986; internal medicine & pediatric residency, Vanderbilt University Medical Center, Nashville, TN, 1986-90; endocrinology, metabolism, diabetes fellowship, Wilford Hall Medical Center, San Antonio, TX, 1991-93; elected by Northeast MS Medical Society.

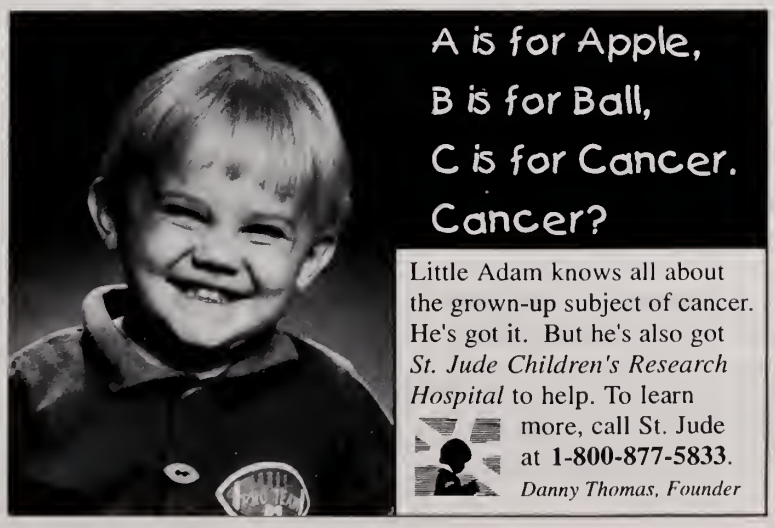
SMITH, MICHAEL KEVIN, Tupelo. Born Jackson, MS, August 7, 1964; MD Vanderbilt University School of Medicine, Nashville, TN, 1993; medicine residency, same, 1993-96; elected by Northeast MS Medical Society.

TAYLOR, PAMI JO, Jackson. Born Miami, FL, May 22, 1967; MD Louisiana State University School of Medicine, New Orleans, LA, 1993; medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by Central Medical Society.

WADSWORTH, WILLIAM M., Hernando. Born Memphis, TN, August 10, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1993; medicine residency, University of Tennessee Medical Center, Memphis, TN, 1993-96; elected by Desoto County Medical Society.

WHEELIS, MICHAEL L., Natchez. Born Monroe, LA, September 11, 1961; MD Lousiana State University Medical Center, New Orleans, LA, 1987; medicine residency, University of Texas Medical Center & Herman Hospital, Dallas TX, 1987-88 & Louisiana State University Medical Center, New Orleans, LA, 1990-92; elected by Homochitto Valley Medical Society.

WHITE, MARSHALL N, III, Pascagoula. Born Mobile, AL, August 25, 1963; MD University of South Alabama School of Medicine, Mobile, AL, 1992; ob/gyn residency, University of South Alabama Medical Center, Mobile, AL, 1992-96; elected by Singing River Medical Society.



Alice Margaret Gorton, MD of Philadelphia, **Grayden A. Tubb, MD** of Fulton, **Richard Gerald Burris, MD** of Monticello, **Terry E. Westbrook, MD** of McComb, **Elmo Gabbert, MD** of Meadville, **Hernando Cartes Payne, MD** of Greenville, **James S. Poole, MD** of Liberty, **William B. Larkin, MD** of Bude, **Guy Farmer Sr., MD,** of Calhoun City, **Nancy Elaine Weible, MD** of Hattiesburg, **Dayton E. Whites, MD** of Lucedale, **Thomas E. Benefield, MD** of Gulfport, **Albert B. Britton, MD** Jackson, A. **Keith Lay, MD** of Bay Springs, **Gary Allen Nelson, MD** of Clinton,, MD of **Linda F. Chidester, MD** of Mantachie, **George E. Howell, MD** of Meridian, **Thomas E. Vanderloo, MD** of Columbia, **Pravin P. Patel, MD** of Coldwater, and **Bharat R. Patel, MD** of Laurel, are some of the physicians who have completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians (AAFP), the national association of family doctors. AAFP members are required to complete a minimum of 150 hours of accredited continuing medical study every three years. Headquartered in Kansas City, Missouri, the AAFP was the first national medical group to require members to keep up with medical advancements through regular continuing medical education.

Grace G. Shumaker, MD joined Jackson Oncology Associates as a new associate on August 1, 1996. Dr. Shumaker, a graduate of the University of Mississippi School of Medicine, (UMC) did her internship and residency in internal medicine at the University Medical Center. She then completed a medical oncology fellowship at the University of Washington in Seattle, Washington. She is board certified in both medical oncology and hematology. Since she completed her training she has been on staff at the UMC Division of Hematology, holding the title of Assistant Professor of Medicine.

Kelly S. Segars, Sr., MD, of Iuka, was featured in the April 18th issue of American Banker Magazine. The article quoted, "Community bank presidents are often integral members of their towns, but perhaps few more so than Mr. Segars divides his time between helping run his bank, $115 million-asset First American National Bank, and his medical practice. That's right--he's a bank president and a doctor."

O.B. Wooley, Jr., MD, Thomas L. Wiley, MD, John R. Wooley, MD, and **Virginia A. Jones, MD** of the Woman's Clinic announce the addition of **Barbara Davey-Sullivan, MD** to the practice and the opening of a new, full time satellite office in Ridgeland. Located at 680 Highway 51 in Parkside Village, The Woman's Clinic will be Ridgeland's only full-time obstetrical/gynecological practice.

Thomas S. Glasgow, MD is pleased to announce that he has associated his medical practice with North Mississippi Medical Services, a regional health care system headquartered in Tupelo. He will continue to see patients in his current location in Oxford.

William D. Frazier, MD has opened Jackson Lung Clinic. Dr. Frazier is board certified in pulmonary diseases, critical care medicine and sleep disorders medicine.

Frank J. Morgan, Jr., MD of Jackson was appointed to membership on the examination committee and designated its chairman by President James E. West of Alabama at the annual meeting of the Federation of State Medical Boards of the United States, held in Chicago.

Thomas Milhorn, MD, a Meridian physician, was among honorees at the Eudora Welty Film and Fiction Festival. The festival was a joint effort of the Mississippi Writers Association, the Junior League of Jackson, and the Mississippi Film Office. Funds were raised to restore Welty's birth place and to construct a writer's center on the grounds surrounding the home. Dr. Milhorn won second place in the novel category for his newest book "Caduceus Awry," the classical story of man's struggle against himself. The main character is Mark Valentine, a down-and-out, ex-plastic surgeon struggling to overcome

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

alcoholism so that he can get his license reinstated to practice medicine. Unfortunately, he becomes involved with the Mafia and is faced with the problem of being hunted by a hitman. The award was presented at a dinner at Hal and Mals by Dr. Ben Douglas, a local writer who serve as president of Mississippi Writer's Association. Dr. Milhorn's previous book, "Drug and Alcohol Abuse: The Authoritative Guide for Parents, Teachers and Counselors" made the Academic Top 20 Best Seller List in 1994.

Ben Yarborough, MD of Meadville was elected to serve in the National Affiliate Faculty (NAF) for the Pediatric Advanced Life Support (PALS) program of the American Heart Association for Mississippi at the Mississippi Affiliate American Heart Association (AHA) meeting. He will represent the state chapter at national meetings for the next two years. Dr. Yarborough was the first NAF for Mississippi from 1988-90, when PALS was begun as a separate advanced life saving program. The primary responsibility of a national faculty member is to act as a conduit for communication to and from the affiliate ECC committee. National faculty members participate in surveys, written communication between the local and national committees, dissemination of new information throughout the affiliate network, and representation of the affiliate as appropriate.

Susan Buttross, MD, chief of the University Medical Center's Division of Child Development has been selected by Senator Ronnie Musgrove as his public appointee to be part of a special task force to develop Mississippi's administration of federal block grants. Nine state senators and one appointed physician will serve on the task Force on Federal Block Grant Administration was created during the 1996 legislative session and will report its recommendations to the Senate by January 7, 1997. The task force is charged with identifying federal and state funding sources for block grants; investigating needs and delivery systems for services; holding public hearings in each congressional district; and recommending procedures and legislation to implement programs. According to Senate Resolution No. 27, the task force will be dissolved when it presents its report. Other members include **Dr. Ed Thompson,** the state health officer; Don Taylor, executive director of the Department of Human Services; Dr. Tom Burham, state superintendent of education; Ms. Helen Wetherbee, director of the Division Medicaid; Dr. Randy Hendrix, executive director of the State Dept. of Mental Health; and one appointment from the general public by the Governor, which has not been made yet.

Robert E. Germann, MD, PC of Biloxi has closed his practice of neurosurgery.

Mark Hopkins Strong, MD was inducted into membership in Alpha Omega Alpha, national medical honorary, and Phi Kappa Phi, national scholastic honorary. He also received the Carl Gustav Evers Award, the Department of Surgery prize as the most outstanding student in surgery and was recipient of the F.A. Hunt Scholarship, given for academic excellence. In 1995, he received the Virginia Stansel Tolbert scholarship. He will do an internal medicine residency at Duke University Medical Center in Durham, N.C.

Robert R. Smith, M.D., Lon F. Alexander, M.D., and **Alexandre Solomon, M.D.,** of Methodist Neuroscience Associates in Jackson, Mississippi, **Tom McDonald, M.D.** and **Dominic M. Cannella, M.D.,** of Tupelo Neurosurgery Clinic have opened Neuroscience Associates of Columbus for the practice of neurology and neurosurgery.

Thomas E. Goyer, MD a surgeon and physician, has been appointed medical director of a free clinic for working people without health insurance slated to open in Burnsville Sept. 1.

C. Ron Cannon, MD served as faculty co-chairman for a meeting of the Home Study course for the American Academy of Otolaryngology Head & Neck Surgery in Orlando, Florida. Dr. C. Ron Cannon wrote four chapters in the Atlas of Otolaryngology-Head & Neck Surgery.

William Brawner, MD is opening an eye surgery-eye diseases practice in Booneville.

Donald J. Booth, MD, F.A.C.S. is relocating his practice to Gulf Coast Medical Plaza, 180-B DeBuys Rd., Suite 230, Biloxi. MS 39531. **Dr. Steven Miller** will maintain his practice in Ocean Springs.

William C. Ashford, MD now offers Excimer Laser PRK for the treatment of nearsightedness.

William C. Touchstone, MD is now affiliated with the MedTrust Clinics, owned and operated by Humphreys County Memorial Hospital. He will see patients in both Louise and Belzoni.



"Being a doctor has allowed me to provide the best for my family."

DR. JANELLE GOETCHEUS, MEDICAL DIRECTOR, HEALTH CARE FOR THE HOMELESS PROJECT, INC., WASHINGTON, DC

Dr. Goetcheus says that raising her children in a health recovery facility for the homeless is one of the greatest gifts she has given them.

Her gifts to her patients are even greater. Caring for Washington's homeless for almost a decade, she despaired at seeing simple medical problems grow severe when patients lacked a clean, quiet place where they could heal. Her answer was to found Christ House, a live-in respite care facility for the homeless — and home to her family.

Today, this center is part of Washington's Health Care for the Homeless Project. As medical director of both, Dr. Goetcheus is serving in an even greater capacity, reviving health and hope in those she serves.

The **Sharing the Care** program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Health Care for the Homeless, in support of those who, like Dr. Goetcheus, are part of the cure.

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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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When Your Patient Asks: "Doctor, I'd Like to Get the Blood Test For the Breast and Ovary Cancer Gene"

Richard C. Boronow, M.D.

Let's begin with a very plausible scenario. Your patient is 31. She has recently spent a year and a half helping her mother die of ovarian cancer. She also recently learned that a cousin was diagnosed with breast cancer. She has an eight year old son and a four year old daughter. Last week she read a brief piece in the paper about a blood test that could detect a mutant gene that, if found, could mean that she is at extraordinarily high risk to develop breast and/or ovarian cancer in her lifetime. This news item, coupled with her family history, is very much on her mind as she sits in your office, waiting to talk, after the pregnancy test and your exam confirm that she is, indeed, eight weeks pregnant.

Her mind is filled with questions:

- "Should I get this blood test for the cancer gene?"
- "If it's positive, what does it mean?"
- "If it's negative, am I safe?"
- "Should I test my daughter?"
- "I don't have to test my son, do I?"
- "If my child tests positive, should I tell them and, if so, when?"
- "If I am positive, should I tell my family?"
- "And now I'm pregnant; should I get an intrauterine test on my baby?"
- "And if I do, and if it's positive, should I consider an abortion?"
- "And, doctor, how confidential are the results of these tests?"

These are but a few of the many confounding questions that may arise, and the response will often vary with the information as well as personal bias of the individual physician.

The purpose of the communication is to provide a current "state of the information" report with selected references for the interested reader.

MEDICAL GENETICS

Genetics is no longer a simple matter such as brown eyes/blue eyes or male/female. Genetic investigation has proceeded with exponential growth in the last several decades due to a variety of new technologies. Our early understanding of genetics was based on very simple observations based on studies of plants and animals, but changed dramatically about 50 years ago because of the ability to do molecular analysis of genetic material. It was recognized that genes are composed of DNA (deoxyribonucleic acid). In 1953, Watson and Crick described the molecular structure of DNA and in 1962 they were given

the Nobel Prize for this contribution.

In the 1970's technologies for the manipulation and analysis of DNA allowed scientists to locate and identify genes responsible for specific human proteins, to characterize mutations, to learn the nature of protein products, all techniques to better understand mechanisms of disease development.

Interest in mapping of human genes to their relative chromosome locations has been facilitated by cytogenetic and molecular genetic analysis together with family studies. Human gene mapping has become a major effort of human genetic research and the Human Genome Project is now underway on an international basis with the goal of defining and mapping the entire human genome by the year 2005.

THE GENETIC NATURE OF CANCER

The concept of cancer as a genetic disease has gained strength relatively recently. While it is estimated that perhaps 5% of all cancer appears to follow a familial pattern, the great majority of cancers appear to be influenced little or not at all by patterns of inheritance.

On the other hand, many cancers show features consistent with multifactorial inheritance and some appear to have a significant genetic susceptibility to developing cancer, presumably as a result of genetic defects that predispose to cancer.

In addition, there is increasing evidence to suggest that essentially all malignant disease -- even in the absence of an apparent inherited component -- is the result of mutations in somatic cells. Until recently, prevailing opinion suggested that viruses and exposures to environmental agents such as ionizing radiation, chemical toxins, and the like, were the cause of most human cancer. It now appears clear that the underlying cause is *gene mutation* and when specific carcinogenic agents are involved, they are involved by operating at the gene level, causing mutations. The mutations that lead to cancer affect the genes responsible for cell proliferation, for cell development, and for other fundamental cellular activities.

When normal cell regulation is altered, uncontrolled growth may be initiated and a malignant tumor may develop.

BRCA1: THE BREAST AND OVARY CANCER SUSCEPTIBILITY GENE

This communication focuses on a dilemma for all of us in the practice of medicine. We are dealing with a situation where science and technology -- fueled by significant commercial interests -- has brought our state of information ahead of our ability -- as a profession and as a Society in general -- to adequately resolve all the medical, social, ethical and psychologic implications of our technology.

We are not dealing with genetic testing for relatively uncommon clinical problems like cystic fibrosis or Huntington's chorea. We are dealing with malignant disease. Breast cancer afflicts over 180,000 American women annually; ovary cancer, over 25,000 American women annually. At this time 1.25 million Americans are afflicted with cancer annually, and it is projected that within the next decade or two, cancer will be the leading disease in the U.S.

Genetic mapping for many cancers is proceeding at a furious rate. Therefore, the availability of testing for cancer predisposition has profound implications.

The letters stand for BR-breast; CA-cancer; and this is the first major breast cancer gene to be isolated. It is a large gene found on the long arm of chromosome 17. The BRCA1 gene codes for a protein that has a tumor suppressor function. Loss of this function may result in cancer development. Inherited loss of BRCA1 function confers an increased susceptibility for both breast and ovarian cancer.

In 1990 in a paper published in the journal Science, Hall and his colleagues[1] presented what all agreed was the first convincing localization of a breast cancer gene utilizing genetic linkage techniques. They identified the linkage in the chromosomal region 17q21, meaning the 21 region of the long arm, that is the q arm, of chromosome 17.

The paper by Miki et al[2] is credited as precisely identifying the gene BRCA1. The manuscript has 45 listed authors. And one of the authors, holding an academic position at the time, is now the Medical Director of a major commercial genetics testing company.

BRCA1 gene risk of breast and ovary cancer

U. S. women have a 10% risk of breast cancer and a 1% risk of ovary cancer. Even though the numbers of ovary cancer patients is relatively low, the mortality rate is high and ovary cancer is the fourth leading cancer killer among American women.

It is suggested that about 5% of women with breast and ovary cancer carry a BRCA1 mutation and the most recently reported statistical models suggest that these women have an 85% risk of developing breast cancer and a 63% risk of developing ovary cancer by age 70. And they have a 94.5% risk of developing one or the other of these cancers[3] (Table 1).

Table 1

Estimated Cumulative Risks of Breast and Ovarian Cancer in BRCA1-Gene Carriers

AGE (years)	CUMULATIVE RISK OF Breast Cancer (%)	Ovarian Cancer (%)	Either Cancer (%)
30.....	3.2	1.7	3.4
40.....	19.1	6.1	19.5
50.....	50.8	22.7	61.9
60.....	54.2	29.8	67.8
70.....	85.0	63.3	94.5

Modified from Easton, et al, *Am. J. Hum. Genet.* 56:265-271, 1995, with permission

Table 2

Estimated Prior Probabilities of a Particular Constellation of Cases Being Due to the BRCA 1 Gene

Criterion, Cancer Diagnosed, Age (y)	Prior Probability Case Has a BRCA1 Mutation
Single affected	
Breast <30	12%
Breast <40	6%
Breast 40-49	3%
Ovarian <50	7%
Sister pairs	
Breast <40, breast <40	37%
Breast 40-49, breast 40-49	20%
Breast <50, ovarian <50	46%
Ovarian <50, ovarian <50	61%
Families	
Breast only, ≥3 cases	
Diagnosed <50	40%
≥2 breast with ≥1 ovarian	82%
≥2 breast with ≥ 2 ovarian	91%

From Shattuck-Eidens, et al, *JAMA*, 1995, 273 535-541, with permission

In an earlier report [4] these same authors (from the Breast Cancer Linkage Consortium) reported results of a collaborative linkage study involving 214 breast cancer families including 57 breast - ovarian cancer families and concluded that BRCA1 was responsible for almost all families with multiple cases of both breast and ovary cancer, and for approximately half of the families with breast cancer only.

Further, this same group[5] reported that the risk of contralateral breast cancer by age 50 in BRCA1 mutation carriers was 48% contrasted to 7-10% with those negative for the mutation. And the risk grows to 64% by age 70. Another disturbing observation in this study reflected a relative risk of colon cancer and prostate cancer increased 3 to 4 fold over the general population. The male carriers are at increased cancer risk as well as females.

Subsequent reports suggest that another gene, BRCA2, is responsible for almost half of the familial breast cancer cases also, but BRCA2 is not implicated in any increased incidence of ovary cancer. Also, of interest, BRCA2 appears to be associated with an increased incidence of male breast cancer, whereas BRCA1 is not. But there are obviously other factors, and perhaps there is a BRCA3 (or 4?) to be discovered.

The probability of a BRCA1 mutation predisposing to a given cancer setting was reported by Shattuck-Eidens et al in 1995.[6] This was still another collaborative study involving a study of 1086 women with either breast or ovarian cancer. There were nine participating laboratories in the United Kingdom and North America testing for BRCA1 mutations in DNA samples.

Statistical models of sampled patients and families were utilized to estimate the prior probability of a particular type of case being due to the BRCA1 gene mutation.

As seen in Table 2, with a single affected breast cancer patient under 30, the probability was projected as being due to a BRCA1 mutation at 12%; for a single breast cancer patient under 40 due to BRCA1 mutation, it drops to 6%; and for a patient in the 40 50 age group, down to 3%. Similarly, for an under 50 ovarian cancer patient, it is 7%.

Where the model suggests a significant increase is when we get into sister pairs and families as noted. The sister pairs range from 20-60% risk of the process being due to BRCA1 mutation, and here it is of interest that breast and ovary or ovary - ovary are the highest.

And in families with multiple patients afflicted with breast and/or ovarian cancer, the range is from 40-90%.

Familial breast/ovarian cancer - Ashkenazi Jewish population

In 1995, four papers appeared describing a specific BRCA1 mutation in Ashkenazi Jewish women, with the largest report by Struewing and associates[7] from the National Genome Research Laboratories at Bethesda in collaboration with institutions in Jerusalem and San Diego.

They tested DNA samples from 858 unrelated Ashkenazi individuals, unselected for the presence of breast cancer or a positive family history of cancer for the 185 del AG mutation (a deletion of adenine and guanine at the 185 position). 0.9% were carriers of the 185 del AG mutation while none of the reference DNA samples were positive. None of the samples were positive for the 5382 insC mutation (the other commonly observed BRCA1 mutation). Thus, this review suggests that nearly 1 in 100 women of Ashkenazi descent may be at especially high risk for developing breast and/or ovarian cancer.

The majority of the 6 million Jews in the United States appear to be of Ashkenazi heritage. While interest among this population about a "screening test" is high, it is felt by most that it is premature to advocate general population screening. Further, for the public at large, the

estimate of carrier frequency in the general population is generally thought to be around 1 in 800, so screening the entire population for BRCA 1 mutation would be totally impractical.

Inheritance of BRCA1 mutations

Among carriers of the mutant BRCA 1, one allele is normal and one allele is abnormal, so it will be passed on to the next generation 50% of the time.

Two points are important. One is that two copies of the abnormal allele are needed to allow development of the malignancy. Obviously with one mutant allele inherited, the second allele is subject to the random hits of environment, whether nutritional, environmental toxins, radiation, viruses, even psychosomatic factors or any other mechanism.

The other important point is that the male equally is the carrier of the mutant gene. The lay public frequently views any familial tendency of breast or ovarian cancer to be related to the maternal line. However, the mutant gene can come from the male or the female.

And, as mentioned earlier, in families with the BRCA1 mutant, the incidence of colorectal cancer appears to be increased by three to four-fold and the incidence of prostate cancer, quite obviously male only, is increased three to four-fold as well.

Testing for the BRCA1 gene -- a new consideration

Clinical utility may include surgical or other intervention, increased surveillance, lifestyle modifications. However, the problems of sensitivity and specificity have not been entirely resolved. As stated earlier, the 185 del AG and 5382 insC mutations have been identified as the most common that appear to be clinically significant. But over 80 mutations have been identified.

DNA sequencing of the entire gene is very complex, very labor-intensive and costly. Therefore, short cuts are taken (the so-called PCR polymerase chain reaction, the SSCP single strand confrmation polymorphism assay, the ASO test allele-specifc hybridization assay, and the PPT protein transcription-translation assay to mention several) to screen for certain features and pursue in more detail those that are identified. Significant abnormality in areas not screened will be missed. And the clinical significance of many of the less commonly identified variations has yet to be determined.

Therefore, BRCA1 gene testing, at this point in time, may be associated with false negatives (not all significant mutations will be detected) and false positives (not all detectable abnormalities will be significant clinically). Yet clinical action and personal turmoil could be produced.

BRCA1 gene pre-test education and post-test counseling

Most experts feel that BRCA 1 gene testing should be done in the context of a research program. BRCA1 gene pre-test education and post-test counseling for the patients are vital components of genetic susceptibility testing to insure understanding of the implications of the testing and the test results. While this is a laudable goal, we are on the threshold of commercial availability of the test and there are incredible medical, psychological, ethical, and legal implications, all of which have tremendous social ramifications. Competent counselors are not universally available. And yet, even if they were, we as medical practitioners and we as a society have not come up with adequate solutions to these dilemmas.

IMPLICATIONS OF BRCA1 GENE TESTING -- MEDICAL

The medical implications basically may be divided into two topics. The first is what we know about the clinical presentation of patients afflicted (in a familial way) with breast cancer and with ovary cancer. The second is what medical options does one have given a positive testing for BRCA1 mutation.

Familial breast and ovary cancer

Families expressing familial pattern of breast and ovary cancer are marked primarily by earlier age of onset than the usual age for either of these two diseases. Further, the disease tends to be expressed as a more virulent form of cancer. While there are certainly exceptions to both of these generalizations, the generalizations are sufficiently strong to be considered the rule rather than the exception.

It is important to stress, however, that it is estimated that only 5-10% of breast and of ovarian cancer falls into this category of familial or highly-penetrant genetic inheritance. Therefore, if there are in excess of 180,000 new breast cancers annually, 9,000 to 18,000 would be due to the familial tendency, and if there are about 25,000 ovary cancers annually in the U.S., 1,250 to 2,500 of them would be familial in nature.

So these entities, while apparently quite real, are also relatively uncommon. The larger question of random genetic predisposition was referenced in the New England Journal of Medicine studies in early 1996 [8, 9, 10]. Thus, while the desire for genetic testing will be highest in families with multiple cancers, others, particularly in more enlightened communities and certain populations,

specifically of the Ashkenazi Jewish heritage, will increasingly be pressing for genetic screening.

RECOMMENDATIONS FOR THE CARRIER OF THE BRCA1 MUTANT

With the estimate of developing breast cancer as high as 85% by age 70 and the risk of developing ovary cancer as high as 60% by age 70, a variety of recommendations have been made, yet we have no impact data confirming clinical benefit. By inference, however, some manipulations that are likely to reduce the risk may also be associated with definable side effects.

PROPHYLACTIC SURGERY

Breast cancer

Sufficient experience has accumulated with subcutaneous mastectomy to recognize that not all breast tissue (90 to 95% of breast tissue at best) is removed and breast cancers have developed. Therefore, the consensus is that if prophylactic surgery is elected by a woman, she undergo bilateral total mastectomy rather than subcutaneous mastectomy. Reconstructive surgery is more satisfactory with the subcutaneous mastectomy, however.

Ovary cancer

Up until recently, prophylactic oophorectomy was generally recommended by age 35 to women in families in which two first degree relatives (mother/sister/daughter) had already been affected (Piver 1993,[11], Struewing, 1995 [12]).

Patients who have had ovaries removed and have on occasion been found to have intra-abdominal "ovarian" carcinomatosis. The causes for such development are (1) there may have been an occult ovarian malignancy present at the time of oophorectomy that had metastasized microscopically and was not clinically detectable, (2) the source of the malignancy may be ectopic ovarian tissue, (3) the oophorectomy itself may have been incomplete, (4) the source of the malignancy may be the peritoneum which is derived from coelomic epithelium, the same embryologic origin as the surface epithelium of the ovary, the histologic type of more than 90% of all ovarian cancers.

So the entire abdominal peritoneum may be at risk for malignant transformation and, while one may remove the ovaries as the most likely source, it may not remove all at risk tissue (Piver 1993 [13], Tobacman 1982 [14]).

Since inherited BRCA1 mutations cause most familial ovarian cancer, the enthusiasts of BRCA1 testing suggest that the need for prophylactic oophorectomy can now be determined by testing for mutations in this gene and patients who do not carry this mutant do not need prophylactic oophorectomy despite a positive family history. Some suggest that this may be ascribing too much sensitivity to the testing as we currently understand it.

INCREASED SURVEILLANCE INTENSITY

Breast cancer screening

- Monthly breast self-examination
- Annual diagnostic mammograms
- Physician breast examination at 4-6 month intervals

Problems

- No data to suggest effectiveness of this approach.
- Women at high risk are often less than 50 and are currently not included in routine surveillance.
- Screening studies have not demonstrated a reduction in mortality for women in this age group. Studies, however, have suggested that a significant percent of cancers diagnosed are found mammographically, suggesting the potential benefit of mammographic screening.

Therefore, for BRCA1 carriers --

- Start mammographic screening at least 5-10 years before the age of the youngest case of breast cancer in the family.
- No data on twice-yearly screens (increased radiation exposure versus benefit of early diagnosis)

Ovary cancer screening

- Pelvic exam
- Transvaginal ultrasound
- Serum CA-125
- Combinations

Problems

- No data to support the benefit (ACOG)[15]

CHEMO PREVENTION STUDIES

Breast cancer

- Tamoxifen reduces the risk of contralateral breast cancer in women
- Tamoxifen as a chemo prevention agent is being studied in the U.S., in Italy, and U.K., enrolling women more than 35 years of age with a strong family history

Ovary cancer

- Use of birth control pills for more than 10 years leads to

an 80% reduction in the risk of ovary cancer (Piver [16]).

IMPLICATIONS OF BRCA1 GENE TESTING -- PSYCHOLOGICAL

The implications of finding a gene that implicates a grave health hazard has only partially been explored.

Up until now, genetic tests looked mainly for genes that would definitely and inevitably produce some sort of inherited disease such as Tay-Sachs disease, hemophilia, cystic fibrosis, Huntington's chorea or sickle cell anemia.

Now we are into the arena of cancer susceptibility genes.

But what we have learned from some of the early experience with other diseases suggests profound psychological implications and the desperate need for counseling and support. The psychological impact on a patient testing for the BRCA1 mutant remains completely unknown although it is inevitable that the impact would be significant.

With regard to the Huntington chorea condition, a genetically associated disease with a defect of chromosome 4 described in 1983, many studies have been done. This is an incurable neurodegenerative disease with an age of onset from 20 to 40 years. Only about haif of the people at risk want to go ahead with genetic testing (Kessler 1987 [17], Adams 1993[18]). Only about half would recommend prenatal testing in a pregnancy situation.

Mastromauro 1987[19] demonstrated that in adult subjects at risk for Huntington's disease, among those who were found to be carriers and who would inevitably develop the disease, 15% became seriously suicidal very promptly.

The psychologic implications are a bit different for the BRCA1 gene testing: They will be at high risk for disease, but not necessarily death. Obviously, to develop breast cancer is not synonymous with death from breast cancer, and early diagnosis affords an excellent salvage rate. On the other hand, ovary cancer is rarely found early and the outcome with ovary cancer is very unfavorable.

Therefore, the patient will be faced with the decisions discussed above. Surgical removal of breasts or ovaries versus increased intensity of surveillance versus chemo prevention.

Interestingly, some authors have suggested that identification of the increased susceptibility by testing BRCA1 mutant positive has in many instances been associated with an increased level of diffidence and noncompliance with screening strategies.

The further manifestations of psychologic impact relate to family relationships and the testing of siblings, children, and other more distant relatives.

IMPLICATIONS OF BRCA1 GENE TESTING -- ETHICAL

Ethicists vigorously debate these issues. We intend to pose many of the questions, but certainly cannot answer them:

Is it proper to test for genetic defects likely to cause diseases for which there is often no effective treatment or cure? Do people really want to know that they are carrying genes for a malignancy that might develop many years or even decades later?

Should the individual's sisters, brothers, children, nephews, nieces and cousins be informed that they may be at risk? Or would they even want to know? Or is there some sort of obligation to inform them?

Should more distant members of high risk families be traced to warn them of a potential danger?

Should children of a patient testing positive be informed? And, if so, at what age? And what will that information do to the vigor, enthusiasm and expectations of a child or young adolescent?

Finally, what about the role of prenatal testing? Pregnancies are frequently terminated electively for social reasons.

Therefore, justification for termination of pregnancy carrying a BRCA1 mutation may be considered perfectly defensible.

On the other hand, however, one could equally argue that terminating a pregnancy because of the possibility of cancer developing in the next 70 or 80 years may be nothing short of eugenics.

And one postscript to the ethical issue that neither Plato nor Socrates ever considered: The ethics of informed consent and confidentiality. Who will gain access to DNA profiles and genetic test results?

Consent ethics

Most of the testing currently done for BRCA1 is in a research setting and in general, the consent is divided into components.

The first is the consent to screen. That is, to be entered into a program studying family histories, pedigrees and the like.

The second is the consent to proceed with the genetic testing. That is, to allow the test to be done to gain the information to document the pedigree and the family history.

The third is the consent to share the information. That is, to allow the information about oneself to go into research programs, networking with intemational consortiums that produce all of these contributions to the medical literature.

And, finally, the consent to be given the genetic test results. Some people are willing to enter into the study. They are willing to be tested. They are willing to have the test done. But they don't want to know the results. And they certainly don't want the result to be given to other family members or friends.

Paramount here is confidentiality and, unfortunately, confidentiality is a very, very fragile issue in these days of computerized networks of data. The suggestion was made by Collins, (the New England Journal of Medicine editorialist, in January 1996 [10])that the federal government should set up a registry to collect BRCA1 study information. The implications of state-controlled data banks are worrisome. The State-imposed infringement on patient privacy already on the books in the state of Maryland (House Bill 1359, passed in 1993) with a similar law being proposed in the state of Massachusetts and in current legislation in Washington, DC (House Bill H.R. 3160)[20] are sad examples of violation of the doctor-patient relationship.

The centralized, computerized, Maryland medical care data base requires detailed information on every visit. Abuse was almost predictable. Indeed, in June 1995, the Baltimore Sun reported that 16 Maryland HMO salesmen and 8 Maryland government employees were charged with bribery and the selling of thousands of confidential patient records to competing HMO's [20]. Thus the assurances of confidentiality by responsible people involved in the Human Genome project[10] are undoubtedly well-intentioned, yet once patient records are the property of the State, personal privacy is surrendered.

IMPLICATIONS OF BRCA1 GENE TESTING -- LEGAL

This, of course, relates to what use may or may not be made of the results of BRCA1 gene testing. Or for that matter, other gene testing. And who, by whatever means, might access this information.

Problems with insurance, either life insurance or health insurance: Is it legal for an employer or insurance company to request results of genetic testing or to deny coverage, for example, on the basis of "pre-existing condition"? What if information that is thought to be confidential and private actually is obtained through whatever means by an insurance company or employer and there are adverse effects on the individual? Who, if anyone, is legally liable for this breech of confidentiality?

The interested reader is referred to "Genetic Discrimination and Health Insurance: An Urgent Need for Reform" by Kathy L. Hudson et al in Science, volume 270, October 20, 1995 [21].

CONCLUSIONS

BRCA1 testing is complicated. The screening tests employed use several short-cut techniques so that the sensitivity may be limited and there certainly could be false negatives as well as false positives. The significance of some of the mutations may be less important than others and this matter has not been resolved with finality.

Complete analysis of the entire gene is extraordinarily labor-intensive and costly because it is so time-consuming.

The change in information continues in this rapidly evolving area of scientific endeavor. What may be considered appropriate today may change considerably in the next 6 to 12 months.

In terms of application of the test, there are no easy solutions. We have the technology on the one hand that is bringing the test to availability and we have the uncertain implications and unresolved medical, legal, ethical, social, psychological issues on the other hand that limit our ability to counsel and advise patients wisely.

Social scientists are getting involved and while, on the one hand, geneticists are having a feeding frenzy, the ethicists and psychologists and counselors are doing the same in their own bailiwick [22,23].

Finally, our patients need to share in the decision-making. If the BRCA1 mutant is likely to be found in above 1 in 100 people of Ashkenazi Jewish origin, the prevalence may justify screening studies, particularly pending the result of the large 5000 population study now in progress in Washington, DC. But even if not screening, testing in at-risk families is probably going to be very wide-spread. On the other hand, in the random population if the finding of this mutant gene is only 1 in 800 or 1 in 1000, wide-spread application of the screening technology would be totally inappropriate.

Once the decision is made to test, however, many issues need to be carefully resolved.

We need to counsel our patients. And caution them as well.❑

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Hospice Care in Mississippi

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The June issue of the M.S.M.A. Journal quoted an address by the president of the AMA entitled "Issue at the End of Life is Quality of Care" which states the entire concept of hospice is now being recognized in the United States as part of the continuum of health care. Today's hospice concept dates from ancient times when small inns were located in the Alps of Europe for over 500 years, usually with some religious orders welcoming and giving refuge to sick, weary travelers.

Hospice in the United States is patterned after St. Christopher's hospice in London which was started over 30 years ago by Dame Sicily Saunders. Hospice in England, Scotland and Wales has long been a continuum of care and hospice for adults and children; both home care and inpatient care covers the entire country. Congress enacted legislation in 1982 which created a Medicare hospice program. Medicare hospice participation has grown at a dramatic rate. The number of hospices participating in Medicare has increased nationally from 31 in 1984 to 2,510 in 1996.

The state of Mississippi finally recognized the need for legislation to allow hospice to become a licensed, regulated health care service and after two years of legislative action, hospice became a Medicaid and Medicare covered service as of July 1, 1990. Since that time, the Mississippi Hospice Organization has become a statewide organization and has been aggressive in helping the growth of quality hospice care. The licensure division of the state health department implemented guidelines based on federal regulations and strictly enforces them. Hospice care in the home has grown from 5 to 26 Mississippi Hospice Organizations, covering most of the state.

Hospice inpatient care is provided by a few leased beds in skilled nursing homes and hospitals, but Whispering Pines Hospice is the only facility dedicated specifically to inpatient care. Whispering Pines was certified January 1, 1991 and opened with 10 beds and slowly grew to 36 as of April, 1995. It now has a children's section as well as respite care for temporary relief of caregivers of home care hospice patients who may be unable to care for the patient for a short time. Patients come from all over the state; many of them referred by the home hospice organizations when the patient can no longer be cared for at home. Plans are underway for a new and larger replacement facility which will offer additional types of service, especially for children who are suffering from a long illness, are not at the terminal stage, but need temporary respite care. Like the hospice of long ago, Whispering Pines was founded by a religious group, the

Ecumenical Health Care Organization, which is made up of the Catholic, Episcopal and United Methodist churches,whose bishops head the Board as well as other denominations. We too care for weary travelers at the end of life's journey.

Hospice in the United States has finally been recognized as a very necessary part of patient care when curative care becomes futile, torturous and excessively expensive and palliative care, especially pain control, becomes the physician's necessary method of caring for the terminally ill patient. Many physicians see death as failure, having been trained to think that way from medical school. But, allowing a patient to have a comfortable and peaceful passing is not a failure. Rather, giving proper treatment until the end of life is a caring, humane succession. Today's knowledge and proper use of medication should never allow a patient to become so pain-ridden that suicide is the only method of relief.

All types of hospice provide care totally without any cost to the patient or family except for personal items. There are no restrictions on providing needed medications or medical equipment regardless of the cost. The only requirement is that prescribed medication and equipment is for palliative rather than curative care. The patient must have a medically proven diagnosis which normally would indicate a life expectancy of 6 months or less. The only restriction for inpatient care is active tuberculosis or hepatitis B.

Physicians well-trained in pain management and assisted by a compounding pharmacist assure that the medications needed to keep the patient comfortable are available, prescribed and properly given. All cases are reviewed on a regular schedule and updated daily if necessary as the illness progresses to its ultimate finish.

Providing care to the loved ones as well as the patient is a very vital part of hospice. Spiritual and social care is just as important as the medical aspect of hospice care. The combined knowledge and skill of an interdisciplinary team of professionals; physicians, nurses, social workers, therapists, and counselors, in addition to volunteers coordinate an individualized plan of care for each patient and family. Hospice reaffirms the right of every patient and their loved ones to participate fully in the final stage of life.

Chaplains and social workers help the loved ones to understand the illness and what to expect, to resolve problems within the relationships and find a measure of peace during the dying process. The patient is helped to accept the facts of the illness and to find peace with it. Many times this brings peace through settling unfinished affairs, reestablishing family bonds and finding a personal faith that may have been thought lost. Individual religious beliefs and church affiliations are respected and clergy of all faiths are also encouraged to assist with the comfort of the patient and loved ones. Every hospice contacts the loved ones and follows them for a year after the death of the patient to help with the grief process and extend any assistance possible to help with their recovery.

Volunteers are a very important part of hospice. Doctors, priests, ministers, medical personnel and individuals, who have only the desire to assist with the care of the terminally ill and their loved ones, are involved in all of the hospice programs. Federal regulations require a certain number of volunteer hours per year to meet requirements for licensure. All hospice have a training program that prospective volunteers must complete before being asked to assist with patients or families. No hospice organization can give total care without volunteers helping in so many ways.

Funding issues presently are as uncertain as for all other areas of health care, but the National Hospice Organization to which most hospice belong, report that government officials still seem to think positively about the future of this continuum of care. Statistics show that hospice care is a cost effective service. Social Security statistics show a 1994 estimate of $1,756.00 per day hospital cost, as opposed to HFCA 1994 estimate of $91.00 per day for hospice home care. According to the Journal of the AMA, patients not enrolled in hospice care spent 23 of their last days in the hospital, while hospice patients spent only eight days in acute care settings. However, it should be noted that cost-effectiveness is not the only rational for hospice care. In fact, the best argument for hospice may be that it is a humane and compassionate way to deliver health care as well as the other supportive services not available in a hospital setting.

Dying with dignity is the goal of everyone and hospice allows a patient to do this in the comfort of home or the home-like atmosphere of an inpatient hospice, in a loving atmosphere, surrounded by friends and family, along with a caring staff dedicated to making this passing as natural and pain free as possible, so that peace, comfort, and dignity are maintained. To deny a patient the possibility of a peaceful ending of life when all curative efforts are useless should be regardless as cruel and inhumane, but we all know it is still happening. Hopefully, the medical profession is now recognizing the value of this new continuum of care and considers it a part of their professional obligation to the patient for end-stage treatment.❑

Statistics: *Mississippi Hospice Association*
Hospice Association of America

MISSISSIPPI HOSPICE ORGANIZATION (MHO)

About MHO

Mississippi Hospice Organization (MHO) is affiliated with the National Hospice Organization (NHO), The member organizations must be accredited by the licensure division of the State Department of Health and be in good, standing. Quarterly meetings are held and topics for continuing education are presented. A yearly convention is held with national speakers presenting a diverse program. MHO has grown rapidly into a truly professional organization and is greatly responsible for the quality of hospice care in Mississippi.

The affiliation with NHO provides information of national importance, especially in the area of legislation. The organization sends representatives into each district to research the problems ocurring in the area and takes information back to Washington to be reviewed, looking for similarities in other regions and assessing the need to lobby for possible changes in regulations. Information is readily available to members on the HFCA requirements of operation and any other operating problems.

NHO also provides information to the medical profession and the general public to assist with education and understanding of this continuum of care.

The following hospice are MHO and NHO members:

Apple Tree Hospice
Attn: Dir., Lil Bramlette,
P. O. Box 299,
Natchez, MS 39121
(601) 446-8000 Fax: (601) 442-3691

BMH - Golden Triangle Hospice
Attn: Dir., Mary H. Nichols, RN,
P.O. Box 1307,
Columbus, MS 39703
(601) 243-1173
Fax: (601) 243-1651 or 243-2094

ComfortCare Hospice
Attn: Dir., Shawn Smith, RNC,
P. O. Box 607,
Laurel, MS 39441
(601) 426-4416 Fax: (601) 426-4084

Delta Area Hospice Care
Attn: Gloria Blakly
P. O. Box 5915,
522 Arnold Ave.
Greenville, MS 38701
(601) 335-7040 Fax: (601) 335-7027

Forest General Home Care Hospice
Attn: Dir., Pat Sneed,
200 South 29th Avenue,
Hattiesburg, MS 39401
(601) 288-2500 Fax: (601) 288-2503

Friendship Hospice of Natchez
Attn: Dir., Cindy Paul, RN,
133 Jefferson Davis Blvd.,
Natchez, MS 39120
(601) 445-0307 Fax: (601) 442-7409

Hospice Care Foundation, Inc.
Attn: Dir., Rachel Goodman, RN,
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Vicksburg, MS 39161
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Hospice of Central MS/BRHVN
Attn: Dir., Jean Berch,
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Brookhaven, MS 39601
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Hospice of Central MS, Inc.
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(601) 336-9881 (1-800-273-7724)
Fax: (601) 981-Ol5O

Hospice of Light
Attn: Dir., Jack Cleary,
4341 Gautier-Vancleve Rd., Suite 4,
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(601) 497-4312 Fax: (601) 497-9035

Hospice of North MS
Attn: Dir., Renee Wright,
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Hospice South,
Attn: Dir., Bob Horton,
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Magnolia Health Service & Hospice
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North MS Medical Center
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Physicians Hospice
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Prime Care Hospice
Attn: Dir., Emry Oxford,
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Greenville, MS 38701
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Quality Hospice of the Gulf Coast, Inc.
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Ruth Hospice Care
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Slidell Memorial Hospice
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Sta-Home Hospice, Inc.
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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XIV

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Pathological Findings:	**Evelyn S. Perry, M.D.**

CASE PRESENTATION

The patient is a 19 year old black female who presented to her local physician complaining of hoarseness. She was diagnosed with laryngitis, and was treated with a course of oral antibiotics. She did not respond and was subsequently seen by an Otolaryngologist at UMC. She reported a two month history of sore throat and hoarseness. Indirect laryngoscopy revealed paralysis of the left true vocal cord. The initial CXR demonstrated a mass within the mediastinum without evidence of parenchymal lung disease. The patient underwent a CT scan of the chest which demonstrated a soft tissue mass within the superior portion of the mediastinum encasing the aortic arch, the origin of the great vessels, and the descending aorta to the level of the diaphragm. No hilar adenopathy or evidence of parenchymal lung disease was seen. CT scan of the abdomen/pelvis showed multiple scattered low density areas in the kidneys primarily in the cortex. At this time a PPD was placed and was negative with a positive control. Lab work was normal except an ESR of 80 and a Potassium level of 3.4 mg/dl.

Thoracic Surgery was consulted and an outpatient mediastinoscopy with biopsies was performed. Although suggestive of undifferentiated sarcoma, definitive diagnosis could not be made. Repeat biopsy was recommended. No granulomas were seen in the initial specimens and all stains and cultures for infectious etiologies were negative.

An outpatient video-assisted thoracoscopy (VAT) was planned; however, her preoperative blood pressure was found to be 218/136 with a heart rate of 82. Repeat blood pressure readings were of similar values in all extremities. The patient gave no history of hypertension. Her recent blood pressures had been normal in the clinic and in the outpatient surgical area.

The Hypertension service was then consulted and admitted the patient the following day for further evaluation. She denied experiencing palpitations, flushing, dyspnea, or weakness. She did describe "dull" chest discomfort which had been present for several months without any associated symptoms.

Her past medical history was essentially unremarkable. Her surgical history was only as above. She was on no medications. Social history was negative. She was a full-time student. Family history was pertinent only for a mother with hypertension. Review of systems was essentially negative except for an occasional, mild headache.

On physical exam she was afebrile with a respiratory rate of 18. Her blood pressure was 230/130 with a pulse of 93. She was 5'1" tall weighing 119 lbs. In general, she was a well developed, well nourished, black female in no distress. Skin was unremarkable with no lesions or rashes. HEENT exam was essentially unremarkable. Her discs were sharp. There was no papilledema and no AV nicking. The neck was pertinent for the absence of JVD or bruits. There was no goiter or adenopathy palpated. Cardiovascular exam demonstrated a regular rate and rhythm without murmur, gallop, or rub. The PMI was felt to be normal. Her lungs were clear. The chest was symmetric and non-tender. The abdomen was flat, soft, and non-tender. No bruits, masses, or organomegaly were detected. Her extremities were essentially normal. There was no cyanosis or clubbing. Pulses were full throughout. Neurologically, she was intact.

Initial laboratory results showed a sodium of 139, Potassium of 3.4, a BUN of 6 with a creatinine of 0.9 and glucose of 78. Her white blood cell count was 6,900 with a normal differential. Her hematocrit was 36, and her platelets were 453,000 with 65% segs, 25% lymphs, and 8% monos. Her chem 15 was normal. The LDH was 608. A urinalysis was normal with occasional bacteria and one WBC/HPF present.

Upon admission, laboratory studies to evaluate the etiology of the hypertension were ordered. The patient was begun on Nifedipine 30mg po TID with a fair response. An aortogram with renal arteriograms was obtained revealing an irregular contour of the descending thoracic aorta with minimal, smooth, focal dilatations. The lumen of the abdominal aorta appeared normal. No evidence of main renal artery stenosis was seen; however, focal areas of narrowing and irregularity affecting several of the intrarenal arteries were present bilaterally. The renal contours were normal in size. Also, patchy nephrograms were noted with several luciencies present.

The patient's blood pressure was controlled with oral medications. A VAT was then performed revealing the diagnosis. She was discharged home five days later in stable condition.

Dr. Meeks: The first thing I will do is try to find salient features that are distinctly abnormal for which there is a relatively small differential diagnoses. Particularly in this 19 year old person, I would use the principle of Okam's razor. I would try to account for all the abnormal findings with one disease process. The mediastinal mass is a distinctly abnormal finding for which there are large differential diagnoses that are categorized based on different locations. You would have to get tissue of this large lesion that sounds very suspicious for being a malignancy because of its extensiveness and because it is apparently invasive. The other distinct abnormality is an x-ray finding of multiple hypodensities of the kidney on a CT scan. With hoarseness, vocal cord paralysis and the mass on CT, my first thought was that those hypodensities were probably metastases to the kidney. Under other circumstances, I would not have been very impressed by the mild hypokalemia, but I think in this case the mild hypokalemia is a pertinent abnormal finding. Another very important problem warranting consideration is the onset of acute severe hypertension. It is obvious this lady does not have essential hypertension; she is only 19, and we are told she has never been diagnosed with hypertension and at multiple clinic visits her blood pressure was normal. Suddenly her BP is elevated to 218/136. With acute onset of severe hypertension you have to consider the differential diagnoses of secondary forms of hypertension. The dull chest pain and occasional headache are not very specific. The aortogram is distinctly abnormal. Abnormal renal arteries are also described.

I have identified three salient clinical features. First, mediastinal mass: The left recurrent laryngeal nerve traces down into the thoracic cavity. If you get impingement of that nerve, you can get left vocal cord paralysis and hoarseness and she has an extensive mass in her mediastinum, so certainly those must be related. The extensive mass can account for her dull chest pain. It is encasing the entire arch of the aorta, the take off of the great vessels, and the entire length of the thoracic descending aorta.

I'll go over the differential diagnoses of the mediastinal mass. With an anterior mediastinal masses, one must consider the "three T's" - thymoma, teratoma, and substernal thyroid. Other masses that can be located in the anterior mediastinum include parathyroid adenomas, aortic aneurysms of the ascending aorta, lymphoma, and lipoma. Thymoma is a possibility, but it typically occurs in an older age group. Although they can be pathologically benign looking, they can be aggressive clinically. It is possible that a thymoma could present in this manner. Teratomas occur equally in males and females and that would be another possibility, but the other types of germ cell tumors are very rare in women. Another possibility is a lymphoma. Since she is a young female, either Hodgkin's disease or non-Hodgkin's lymphoma could be seen. With Hodgkin's disease only 40-50% of people will have mediastinal involvement and in only 5% is it the sole involvement. There is no mention of lymph nodes elsewhere, so Hodgkin's is a low possibility. On the other hand, non-Hodgkin's lymphomas can present with solitary mediastinal masses.

This lady does not have involvement in the middle mediastinum. Her involvement is in the anterior-superior and the posterior mediastinum. There is no evidence of parenchymal lung disease or hilar lymph node involvement and cultures are negative, so it does not appear to be a granulomatous disease. Posterior neurogenic tumors can occur that can be malignant. I do not think any of these are likely. There were no typical symptoms to suggest pheochromocytoma, such as severe headaches, palpitations, or diaphoresis. One of these symptoms should be present in most patients with pheochromocytoma. Paragangliomas can also produce catecholamines and give you hypertension and would be a rare possibility.

Two other mediastinal tumors appear to be more likely. You can see primary carcinomas or sarcomas in the mediastinum. I think Adkin's tumor is the most likely diagnosis which is a poorly differentiated carcinoma of the mediastinum.

In summary, a number of these mediastinal lesions could be responsible for this extensive mediastinal mass. Obviously, a definitive diagnosis will require histologic confirmation.

Let us turn our attention to the onset of accelerated hypertension. In this setting one must consider secondary causes of hypertension. Cushing's syndrome is unlikely in this patient since there is no hyperglycemia or characteristic body habitus. Although a pheochromocytoma appears unlikely, it would be reasonable to obtain a spot urine for metanephrines to exclude this diagnosis. Primary hyperaldosteronism is unlikely to cause this kind of abrupt onset of severe hypertension. Interestingly, the patient does have spontaneous hypokalemia which necessitates an evaluation for hyperaldosteronism. There is no mention that the patient has been vomiting, taking diuretics, or having diarrhea which might account for the hypokalemia. Although primary hyperaldosteronism is unlikely, a secondary form of hyperaldosteronism would still be possible. There is nothing clinically to make one

suspect hyper- or hypothyroidism, and at this age she should manifest obvious clinical findings with these disorders. There is no evidence of renal insufficiency from the information presented.

Coarctation of the aorta was considered because the aortogram shows encasement of the entire aorta. At some point there could be compression of the aorta resulting in an acquired form of coarctation of the aorta. But, it was mentioned that blood pressure and pulses are equal in the lower extremities and the upper extremities, which does not support coarctation. What about renovascular disease? When considering renovascular disease, one thinks of atherosclerotic disease in older people. This patient almost certainly would not have atherosclerosis without a history of familial hypercholesterolemia. Fibromuscular dysplasia should be considered in a young person. It can occur in Afro-Americans, but much less commonly than in fair-skinned Caucasians. Another cause of acute onset of hypertension is an embolus to the kidneys causing a renovascular type of hypertension. There are reports in Kaplan's textbook on hypertension of metastatic lesions to the hilum of the kidney compressing renal arteries and causing a renovascular form of hypertension. Trying to account for all these salient clinic findings, one could conceive of emboli which originated in the thoracic aorta and traveled to the kidneys resulting in renal cortical infarcts.

Now, I will consider the abnormal radiologic and laboratory tests. My initial impression of the abnormalities found on imaging tests of the kidneys were metastases to the kidneys producing multiple luciencies on the CT scan. But the aortogram with the renal arteriograms demonstrate that the intrarenal arteries are abnormal. There is the possibility there could be renal metastases that were compressing some intrarenal arteries causing ischemia resulting in hyperaldosteronism. However, I would not expect such a process to happen so abruptly. More likely would be segmental renal infarctions, which resulted in hyperaldosteronism. They often will get fever, leukocytosis, and flank pain. They may get accelerated hypertension, renal insufficiency, proteinuria, and/or hematuria. But some people who get large renal infarcts do not have these findings. The fact that she does not have flank pain, proteinuria, hematuria, fever, or leukocytosis does not dissuade me from that being a possibility. If there were multiple small infarcts in the cortical areas where the glomeruli are located, I think this patient could develop ischemia leading to hyperaldosteronism accounting for the hypertension, as well as the hypokalemia.

The elevated sedimentation rate is not specific. Malignancies of all sorts are related to high sedimentation rates. There is nothing to make me consider a connective tissue disorder, infection, or end-stage renal failure which might cause an elevated sedimentation rate. If this mediastinal mass is a malignancy, it would account for this abnormal laboratory finding.

I was not given any indices for the anemia, so I presume it does not have any significance. The anemia is mild. There are a couple of things I would like to know to further evaluate the elevated LDH. First, it is not dramatically elevated, so I am not sure if it is significant at all. You can get an elevated LDH with malignancies. Carcinomas, lymphomas and leukemias are the malignancies most likely to result in an elevated LDH. We have already mentioned primary carcinoma of the mediastinum and lymphomas. It is possible that any of these malignancies could give the elevated LDH. Hemolysis is another consideration that could account for the elevated LDH. Three other things that may result in an elevated LDH_1 are myocardial infarction, intramedullary hemolysis or renal infarction. To differentiate these three disorders, one could obtain a urinary LDH, which would be high in renal infarction but not in hemolysis or myocardial infarction.

Finally, the pathogenesis of the mild hypokalemia must be considered. She has not received insulin, sodium bicarbonate, or Beta agonists which would "push" potassium into the cell. There is no evidence of GI potassium loss, diuretic usage or an osmotic diuresis resulting in renal potassium losses but hyperaldosteronism would explain the hypokalemia.

To summarize, I think lymphoma, teratoma, the so-called Adkins tumor (undifferentiated tumor of the mediastinum), or any of the neurogenic tumors (particularly the malignant ones) would all be possible diagnoses. I suspect the mediastinal mass compressed the recurrent laryngeal nerve causing the vocal cord paralysis and hoarseness, resulted in the high sedimentation rate, the dull chest pain, and an anemia of chronic disease.

It is conceivable that this presumed tumor, which is encasing the entire aorta, could actually embolize to distal sites. Or there could be blood stasis and thrombosis occurring in areas of focal dilatation seen on the aortogram which could embolize. Another possibility could be marantic endocarditis, which is a noninfectious, valvular, thrombotic process that occurs with underlying malignancies and is very uncommon. I think that renal artery emboli from one of the above sources with resultant hyperaldosteronism is accounting for the acute hypertension, hypokalemia and elevated LDH. From the description of the renal arteriogram, there is irregularity within segmental renal arteries which would be consistent with emboli. These lesions are primarily in the cortex where the glomeruli are located and would be more apt to result in ischemia of the juxtaglomerular apparatus resulting in

hyperaldosteronism.

To confirm the proposed scenario which I described, I would check plasma renin and aldosterone levels and perform a Captopril test to demonstrate a significant drop in blood pressure in response to an ACE inhibitor. A renal biopsy could be performed, although I would not pursue this more aggressive approach until I knew the etiology of the mass in the mediastinum. Presuming the above is accurate, one could treat her with an ACE inhibitor and/or a beta blocker to interrupt the renin-angiotensin-aldosterone loop at different points. Another therapeutic option for her hyperaldosteronism would be a potassium-sparing diuretic.

Dr. Ellis: On one of our first chest films, there is a soft tissue mass in the mediastinum. The aortic knob is much too prominent for this patient and the descending aorta is a little lumpy. Her lung fields are clear and there is no bony abnormality. The lateral chest appeared normal. There is an abnormal mass on the CT scan that drapes over the aortic arch. It is coating the whole aorta and encircling the descending aorta. This is somewhat unusual for a mediastinal mass. In the abdomen, there are some wedge shaped low density areas in both kidneys. When you see wedge shaped areas like this, it makes you think of renal infarct. You can have tumors like metastases causing defects but they are usually not wedge shaped. On the aortogram, the aorta is a little irregular all the way down. The aorta is lumpy and that is highly abnormal, especially in a 19 year old. The renal arteriograms show irregularity of some of the arteries. On the nephrogram phase, we do see the defects that we saw on CT. The other kidney shows the same thing, essentially. You have defects and the arteries are a little irregular and narrowed. We never see a clear cut cutoff like an embolus would look like. Embolus could cause that irregularity, but the emboli would have had to resolve completely and leave irregularity of the vessels. She had a bone scan that was normal. Our differential of the anterior mediastinal mass would include lymphoma especially in a young person, inflammatory problems such as sclerosing mediastinitis (like you see in histo) and other tumors that were mentioned, sarcoma, and undifferentiated carcinoma. As far as involvement of the aorta and renal arteries, you would have to think of a vasculitis problem; something involving the vessels themselves. It's hard to tie the mediastinal mass and the vascular problem together.

Dr. Perry: Both of the biopsies showed small cells infiltrating fibrous tissue. The first biopsy showed some vesicular nuclei and crushed cells. The crushed nuclei make it difficult to give a diagnosis at all. The second biopsy shows broad bands of collagen and numerous small lymphocytes scattered around and clustered between the bands. There are quite a few capillaries. Probably some of those vesicular nuclei on the first biopsy were endothelial cells that didn't crush as easily. The first biopsy had many lymphocytes that were crushed. The diagnosis is sclerosing mediastinitis. It is sometimes associated with Histoplasma and rarely TB infection. It is thought to be an exuberant fibrotic response to involvement of mediastinal nodes. We did a GMS and AFB stain and did not find any organisms.

Diagnosis: idiopathic sclerosing mediastinitis; an unusually rare disease process with this kind of presentation. In the more acute forms, it is thought to be related frequently to Histoplasma or TB. Rarely, it is associated with retroperitoneal fibrosis and possibly methysergide use. In this case, at her age, it is thought to be idiopathic.

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The Changing Role of Medicare Carriers

Medical Practice Financing and Systems
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Introduction

The traditional role of Medicare carriers will undergo major change over the next few years as new policies and programs are developed by federal policymakers seeking to improve the Medicare program and respond to major forces that are reshaping the current health care environment. For example, efforts to reform the Medicare program by Congress and maintain its trust fund solvency will continue. Widespread support for expanding the health care choices of Medicare beneficiaries could make available more health plan options, including managed care and additional fee-for-service options, as well as medical savings accounts. Increasing numbers of Medicare beneficiaries may opt for these programs over traditional fee-for-service.

In addition, there is support for proposals that would "privatize" some of the review functions currently performed by Medicare carriers, including adopting the commercial standards and claims processing software used by many private insurers. Finally, the rapid development of information systems technology facilitates increased automation and centralization of claims processing and related activities. These developments will significantly affect many responsibilities currently held by Medicare carriers, reducing the traditional carrier role in claims processing.

This article includes an overview of current carrier functions, describes a number of significant program changes related to claims processing activities that are already underway and their scheduled implementation dates, describes proposed changes to carrier review and lists sources for additional information.

Overview of Current Carrier Functions

The Medicare program contracts with private insurers to serve as Part B carriers to process claims for physician and other services furnished to Medicare beneficiaries. Claims processing includes: establishing patient eligibility, determining and issuing payment for services, conducting medical review of claims to determine whether billed services are appropriate and medically necessary, and providing appeals for claims denials.

Claims Processing

After claims are submitted, carriers determine whether the services provided are covered by Medicare. Payment rules and screening criteria are determined by a small number of national coverage policies and a greater number of local standards developed as local medical review policy (LMRP). Medicare specifies, at a national level, the amount carriers pay for services, including the geographic adjustments and relative values, and a broad range of detailed payment policies.

Once claims are approved for payment, Medicare carriers are required to pay promptly, with the definition of "promptly" depending upon whether the claim is processed electronically or on paper, whether or not the physician participates in the Medicare program, and whether the claim requires special treatment.

Medical Review—The Medicare program limits payment for services to those that are considered to be reasonable and medically necessary. Claims must also be accurate, complete, and properly coded.

Carriers use prepayment and postpayment review not only for making coverage and payment determina-

tions, but also to provide data for two methods of concentrating their review analysis: focused medical review (FMR) and comprehensive medical review (CMR). Whereas previously carriers selected random samples of physicians for review, they have shifted to a more directed combination of FMR and CMR. CMR identifies specific physicians for in-depth review and FMR identifies specific services or diagnoses for close monitoring.

FMR analyzes national and carrier-specific utilization and billing data to identify patterns of overutilization and instances of unusual coding. FMR allows carriers' prepayment and postpayment review efforts to focus on the most significant areas of concern.

CMR consists of in-depth postpayment review of a physician's claims and medical documentation for a specified period of time. Physicians may be selected for CMR if carriers determine that their claims show a pattern of over utilization or billing for medically unnecessary services.

National Coverage Policy

National coverage policy for physician services is developed primarily in response to coverage issues raised by carriers. HCFA also considers the issues of physicians and other health professionals, beneficiaries, equipment manufacturers, public officials, professional associations, or government entities. HCFA may identify other coverage issues in ongoing review of medical literature. If it is determined that a concern merits further consideration, HCFA seeks medical and scientific advice to reach coverage decisions, conducts a literature search, presents the issue to an internal advisory panel of HCFA and Public Health Service staff physicians and other staff health professionals, and submits the issue for review by other government agencies. HCFA is in the process of developing a proposed regulation to codify its national coverage policy.

The AMA has advocated for the more effective use of the expertise of the Practicing Physicians Advisory Council (PPAC) in the development of national coverage policy. The PPAC, composed of 15 physicians and other health professionals, is an advisory body to HCFA on policies that are of concern to the practicing physician community. The PPAC considers the comments of the AMA and other organizations in its discussions of proposed HCFA regulations and carrier manual instructions.

Appeals

When physicians and other providers receive a payment denial, they can appeal the decision by requesting in writing that the carrier review the claim again. The carrier must then provide a reexamination of each aspect of each service in the claim by a person who consults with medical professionals and is trained in medical review. This individual must be a different reviewer than the one who made the initial determination. If the review determination is unsatisfactory to the physician, and the amount in question is $100 or more, the next step of appeal after review is to request in writing that the carrier provide a "fair hearing" conducted by a carrier hearing officer. Physicians have additional appeal rights beyond this level that are similarly restricted by the amount of payment in controversy.

Local Medical Review Policy (LMRP)

Physicians have a much more active role in the development of LMRP, which constitutes the majority of coverage policy used by carriers. Each of approximately 35 Medicare carriers has a Carrier Medical Director (CMD). The CMDs are active at both the national and local levels. Locally, CMDs serve as liaisons to the physician community by educating physicians on LMRP and providing clinical expertise and judgment to effectively focus medical review. Nationally, CMDs participate in clinical workgroups that develop model policies on particular areas of concern.

Each carrier also has a Carrier Advisory Committee (CAC) that provides a formal mechanism for physicians to be informed of and develop LMRP and local administrative policies. Established in each state in 1992, CACs are co-chaired by the CMDs and include representatives from a broad range of physician specialties. HCFA distributes policies it has approved to all CMDs, who may then submit the policies for local consideration by the CACs. The CAC, in turn, is responsible for communicating policy recommendations to the physician community.

The AMA has sponsored forums for CAC co-chairs at recent meetings of its House of Delegates. These forums are organized to assist co-chairs in directing local CAC activities.

Carriers are granted broad discretion in the development of LMRP. Because some local policy is derived from nationally initiated coverage policy, there is some degree of uniformity among locally accepted policies. HCFA maintains a database of all LMRP and is interested in working toward more consistent policy. Nonetheless, this heavy reliance on local policy often results in wide variation in payment policy between carriers.

Changes to Medicare Claims Processing

HCFA plans to begin implementation over the next four years of a new information system designed to improve claims processing operations. The new system, known as the Medicare Transaction System (MTS), will enable the Medicare program to further automate claims processing and related transactions. Implementation of a new, more fully automated system is expected to increase claims processing efficiency and provide significant cost savings to the Medicare program through greater use and uniformity of electronic claims data.

In anticipation of the new system, HCFA recently announced several new data requirements related to the claims submission process, which are scheduled for implementation over the coming months:

- Adoption of a standard electronic claims format,
- Issuance of a new national provider identifier, and
- Development of a new national payer identifier.

Additional details on MTS are provided in the next section.

Electronic Data Interchange Standards

Currently, 70.8% of all Medicare Part B claims are submitted electronically, compared to an average rate of 8% for private insurers. To achieve these high rates of electronic data inter change (EDI), HCFA has provided a variety of incentives to physicians, including faster payment for electronic claims; free billing and remittance software; on-line access to claims status and eligibility data for participating physicians; and access for participating physicians to toll free telephone numbers for electronic claims submission. HCFA has indicated that the agency will continue to aggressively promote use of EDI among physicians and Medicare providers.

Standard Format

Although the HCFA 1500 paper claim form is widely accepted by both payers and physicians, there are over 400 proprietary electronic claims formats. In addition, two non proprietary national standards have been developed; the ANSI ASC X12 837 by the American National Standards Institute (ANSI); and the National Standard Format (NSF), by HCFA.

Effective July 1996, HCFA will require that all physicians submitting Medicare claims electronically use one of two standard formats: the X12 837 format, or the National Standard Format. Proprietary formats will no longer be accepted by Medicare carriers. Advantages of the X12 837 format are the corresponding standards developed by ANSI for related transactions, such as eligibility and claims status inquiries.

A uniform data set for physicians and other health care claims is essential to effective EDI. Development of such a data set is one of the priorities of the National Uniform Claim Committee (NUCC), which is chaired by the AMA in consultation with HCFA. Other national as well as state-level organizations are also working to promote greater use of electronic media in the health care industry.

New National Provider Identifier

Some physicians currently may have multiple Medicare numerical identifiers, in addition to others assigned by private health plans. For example, physicians who treat Medicare patients are identified by the Unique Physician Identification Number (UPIN) but must also report a carrier assigned billing number on the Medicare claim form.

A new system, however, is now under development by HCFA that is intended to simplify and standardize provider identification. It will be used by HCFA to enhance its control over physician and other provider enrollment and participation in Medicare and other federal health care programs.

The new system will assign a unique national provider identifier (NPI) to all physicians and other health care providers who treat Medicare patients, which will serve both as a unique identifier and as a billing number. Physicians will keep the assigned NPI throughout their careers, even if they change specialties or relocate their practice. The new identifiers will be issued

Incomplete or Invalid Claims

As part of its efforts to streamline the claims process, HCFA has developed a new policy to reduce the number of claims that enter into the formal appeals process. Whereas previously, carriers denied incomplete or invalid claims, which would start the appeals process, they must now return such claims to physicians as "unproccessable." Incomplete claims lack required information (eg, no UPIN), while invalid claims contain complete and necessary information that is somehow illogical or incorrect (eg, incorrect UPIN). Carriers must provide an explanation of errors and allow correction or resubmission of the claim.

to physicians in December 1996 and will be accepted by carriers beginning January 1, 1997. Physicians will be required to report the NPI beginning luly 1, 1997, although this grace period may be extended based on carrier experience. Additional information regarding placement of the new identifier on paper and electronic claims formats will be provided by local carriers. NPI directories, similar to the current UPIN directories, will be provided by HCFA to physicians and other health care providers.

The NPI will be linked to an electronic database maintained by HCFA that includes such information as name, practice address, specialty, type of practice, education, licensing, credentials, and any sanctions against the physician or provider. The NPI system is part of an intergovernmental effort that is intended to allow the identification of the same provider across federal programs. Other participating agencies, which are expected to adopt the NPI, include Department of Defense (CHAMPUS), state Medicaid agencies, Department of Veterans Affairs, and the Office of Personnel Management (Federal Employees Health Benefits Program). To encourage use of a nationally uniform identification system across all payers, HCFA plans to make the NPI available to other insurers for use in their claims processing systems, although its adoption would be voluntary.

The AMA has expressed its concerns about the need to protect physicians' confidentiality, as well as the accuracy of baseline information, under NPI implementation. The AMA previously worked with HCFA to determine accuracy of physician data for assignment of the current UPIN. It also has offered its assistance to HCFA on verification of physician source data for the NPI through the AMA Physician Masterfile. The AMA will continue to work with HCFA on development of the new identifier system to ensure that these issues are appropriately resolved.

National Payer Identifiers

HCFA is also undertaking a major new initiative to assign a unique identifier to all payers of health care claims to standardize and simplify coordination of benefits. Payers are currently identified by the Medicare program in multiple ways, resulting in claims payment errors and delays.

PAYERID will be a national electronic database containing unique identifiers for health care payers. It will allow Medicare to track beneficiary coverage by other insurers and better coordinate benefits with state Medicaaid programs, Medigap insurers, and other payers as well as contribute to identification of the appropriate payer in accordance with the Medicare Secondary Payer Program.

A publicity and education effort to reach all payers will begin in August 1996. Special emphasis is placed on major payers with whom Medicare interacts, including Medicaid agencies, Medigap insurers, and those payers who account for the highest claims volume. Carriers will begin to accept the new identifier beginning January 1, 1997. It is anticipated that HCFA will require the PAYERID on claims forms, although an implementation date has not been established. To assist physicians and other providers, PAYERID will assign Medigap insurers with identifiers containing certain digits that will be recognizable as a Medigap payer. Current plans call for the physician and provider community to obtain access to the PAYERID database primarily through health care network operators, claims clearinghouses, and large payers. The AMA, however, is exploring the possibility of HCFA developing a directory of payer identifiers that would be available to physicians who do not subscribe to a claims clearinghouse.

Activities are ongoing to ensure that PAYERID activities are coordinated with health care standards for

Medicare Transaction System

The NPI and PAYERID will contribute to implementation of HCFA's new automated system for processing Medicare claims and related transactions. The new system, known as the Medicare Transaction System (MTS), will integrate claims data from Medicare Part A, Medicare Part B, and Medicare managed care plans into one system. All automated claims processing and related activities will be consolidated at two processing centers, which will replace the varied claims processing systems now used by

EDI Information

The following sources are available for physicians who want additional information about using EDI in their practices:

- The Medicare program maintains a directory of certified electronic billing vendors; contact your local carrier for a directory of vendors in your area.
- The AMA has produced the following EDI publications for physicians:
  - ***Electronic Data Interchange: The Physicians' Primer,*** an eight-page booklet available to AMA member physicians upon request by contacting 312 464-5516.
  - ***Electronic Data Interchange: The Physicians' Guide,*** an in-depth discussion of the goals and benefits of EDI. Cost is $19.95 ($29.95 for non-members) and may be ordered by calling the AMA's toll-free product order line at 800 621-8335.

electronic data interchange. In addition, controls will be placed on the PAYERID application process and access to the database to minimize the potential for fraud and abuse.

Medicare carriers and intermediaries. Implementation is scheduled to begin in late 1997, and HCFA expects the new system to be fully operational by late 1999. As more information becomes available, these dates may change.

Local carriers, however, will remain the first point of contact for physicians and beneficiaries in claims-related activities. For example, physicians will continue to submit all claims to their local carrier, where they will then be transmitted to the appropriate processing center. Carriers will convert paper claims to an electronic format prior to transmission to the appropriate MTS center. Carriers also will continue to perform administrative functions, such as medical record audits, provider and beneficiary education, new provider enrollment, and hearings and appeals proceedings.

When the new system is fully implemented, it is intended to provide physicians with improved access to computerized claims information, including: beneficiary eligibility, pending claims status, payment decisions, and HMO enrollment/ disenrollment. It should also enable Medicare to automatically coordinate health care benefits with other insurers, through incorporation of the PAYERID database discussed above. According to HCFA, the new system also will allow more consistent implementation of new national payment and coverage policies.

To assist beneficiaries, HCFA plans to implement a new Medicare Summary Notice to replace the current Explanation of Medicare Benefits (EOMB). The single form will contain complete information on the beneficiary's Medicare trans actions during a particular month, including all paid bills, coordination of other insurance claims sent for payment, and enrollment status.

The current trend toward consolidation of Medicare carriers is expected to continue as MTS implementation proceeds. With the elimination of traditional claims processing functions, many carriers may choose not to renew their contracts with the Medicare program.

Changes to HCFA's Contracting Practices

Congressional and Administration proposals recently have been advanced that, if implemented, would significantly change the role of local Medicare carriers. These legislative proposals would, to varying degrees, "privatize" some review functions currently performed by local carriers. Included with provisions calling for new programs to combat health care fraud and abuse, one set of such proposals was part of the budget reconciliation conference report adopted by the House and Senate in December 1995 (and vetoed by President Clinton). They are, however, contained in health insurance reform legislation pending as of early June 1996.

The proposed legislation specifically calls for new review entities to perform medical and utilization review,

status as an accountable public program. The AMA believes that all public sector and proprietary review systems used by Medicare should adhere to AMA principles of medical review, including full disclosure of all payment and coding rules.

In addition, the Administration has taken steps to alter HCFA's relationship with Medicare carriers and to give the agency greater flexibility in its contracting authority. Under current law, HCFA may contract only with health insurers to process Part B claims, and is restricted to contracting with entities nominated by health care providers for Part A claims processing. In late 1995 HCFA drafted legislation, the "Medicare Contractor Reform Act of 1995," that would allow the agency to contract with organizations other than health insurers for Medicare claims processing and related transactions. Action on this proposal is not expected until next year. It may be included as part of anticipated Medicare reform that will be considered by Congress in 1997-98.

Conclusion

The role of Medicare carriers is expected to change significantly over the next few years due to a number of factors: increased enrollment in Medicare managed care plans and other alternatives to traditional fee-for-service; consolidation of Medicare carriers' current claims processing functions, and changes in Medicare's contracting practices with claims processing entities. HCFA has already begun implementation of a new more fully automated information and claims processing system that will change many traditional carrier functions. New claims submission requirements, which are related to implementation of the new system, were recently announced by HCFA to become effective over the next several months.

The AMA is committed to ensuring that information on Medicare program changes and other requirements is provided in a timely way, enabling physicians to make the appropriate adjustments in their practices. The AMA believes that physician practices can realize many benefits from greater automation of Medicare carrier operations and claims processing, if these efforts are developed and implemented with appropriate physician input and consideration of physician needs. The AMA will continue to work with HCFA and the Congress to this end. It will also work with HCFA and others in the health care industry towards adoption of uniform data elements and other standards for electronic data interchange. Finally, the AMA will continue to work with members of Congress, HCFA, and other groups to ensure that an appropriate role for practicing physicians is maintained in the development and implementation of new medical policies associated with the MTS and other changes in carrier function.❑

Medical Practice Financing and Systems
Group on Health Policy
American Medical Association

Information Resources

Further information on the program changes discussed above is available from:

- *American Medical News;*
- AMA Electronic Network;
- AMA Home Page on the Internet (http://www.ama-assn.org);
- *Medicare RBRVS: The Physicians' Guide,* the AMA's annually updated book on the RBRVS, including discussion of Medicare payment policies; cost is $49.95 ($60 for non-members);
- Local carrier provider newsletters; and
- Carrier Advisory Committes and state medical associations.

MENTAL ILLNESS AWARENESS WEEK
October 6-12, 1996

Physicians' Recognition Award

Four MSMA members were named recipients of the AMA Physicians Recognition Award in July 1995. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

CENTRAL MEDICAL SOCIETY
Louis Julian Wise,MD
Anne Lee Bridges Yates, MD

SOUTH MISSISSIPPI MEDICAL SOCIETY
Christopher L. Mauldin, MD

SINGING RIVER MEDICAL SOCIETY
Paul Harold Moore, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

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Fred L. McMillan, M.D.

The President's Page

Ya Hoo!

Not Yahoo as on the Internet....but as in congratulations to Dr. Ed Hill. For the first time in the 150 year history of the AMA, Mississippi has its one of "its own" elected to the Board of Trustees of the AMA. Dr. Hill was elected to the Board at the AMA Annual Meeting in June. Having attended the AMA meetings now for about six years - I have developed a much deeper appreciation of the breadth of the AMA and its quick...yes, I do mean quick....response to issues. The first thing that everyone comments on after their first AMA meeting is the amount of excellent background knowledge contained in the reports on issues in the Delegate's handbook.

Secondly, they comment on the realization of how a problem, for us in Mississippi, that seems to have a straightforward solution, can take on a totally different meaning in another state. Certainly there are times when the House of Delegates decides on a direction of action that I think is not in the best interest of Mississippi or my specialty; however, I can see that overall it is the best thing to do. Then, there are times that action is taken specifically because one state or one specialty needs help that only the AMA has the resources to provide. What I am trying to say is... as large as the AMA is overall, being there, I see it as being responsive. I have also seen one other change at the AMA; the House of Delegates is willing and capable of thinking an issue through differently than the conclusions made in an AMA report or that the Board of Trustees might have recommended.

As usual, the House of Delegates took up several hundred issues. Some of those they took action on are: 1) HMO Medical Staffs: This AMA proposal requires that HM0s and PPOs establish formal medical staffs which would provide a mechanism through which physicians could provide input into health plan policies without fear of retribution.

2) Ethics: Because of concerns among some delegates, about the ethical guidelines which the Council on Ethical and Judicial Affairs (CEJA) has rendered, there is an open forum at each AMA meeting for members to voice their concerns directly to CEJA.

3) Universal Accreditation: The AMA is progressively promoting a "Program for Physician Accreditation" that would be the universally accepted standard-setter for physician excellence, thus giving the AMA seal to replace the now fragmented and overlapping physician accreditation used by U. S. health plans.

4) Uninsured Poor: This directive would call on health plans and managed care companies to share the responsibility for the care of the uninsured poor.

5) HMO Profits: The AMA will develop and support legislation, state and federal, to require each health benefit plan to inform enrollees about its profits and how much of each premium dollar actually goes towards health services.

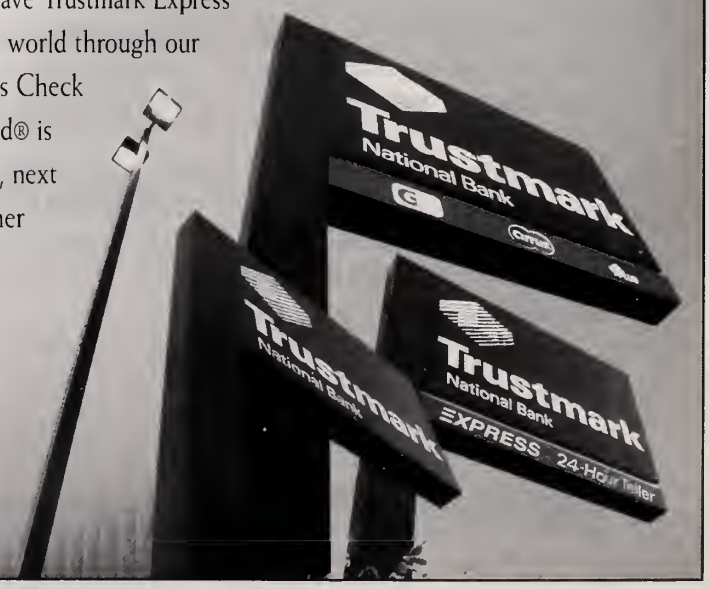
6) Assisted Suicide: In order to adequately treat patients in great pain, the AMA will draft model legislation to insure that physicians prescribing drugs to their patients are not charged with improperly dispensing controlled substances. This is seen as one means of lessening the desire of these patients for assisted suicide by adequately treating the illness - not killing the patient.

These are just some of the issues debated and acted on by the House of Delegates. Still though - the best decision the delegates made was to ask Ed Hill, M. D., to be part of our AMA leadership...Ya Hoo!

Fred

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVII, NUMBER 9
SEPTEMBER 1996

1903

When trying times are upon us, when frustration with the legislature, Washington or the great corporations managing our services drives one to the point of drink, it sometimes helps to look back to the "better" days. During a break at a recent Foundation board meeting I found on a shelf behind me a copy of the MSMA Annual Session proceedings for 1903. Sipping Diet Coke I slipped into the pages and entered another world.

Dr. H. L. Sutherland of Rosedale was taking the podium at the Walnut Street Theater in Vicksburg for the President's Address. He reflected back on the progress made during the thirty years since he had joined MSMA. The self registering thermometer and the hypodermic syringe had made work vastly easier for them all, to say nothing of the miracle of the gelatin capsule. He winced as he recalled the taste of quinine mixed in molasses and said never again, because of that capsule, would humanity have to experience such a flavor.

But he spent more time reminiscing on the Association's work with the legislature. When he began practice in 1873, he knew a man who was retailing whiskey at Christmas. That man was astride a pair of saddle bags, playing doctor, the following April. The MSMA succeeded in their pressure to gain creation of the State Board of Health in 1877. Five years later MSMA pushed for and got passage of the Medical Practice Act, mandating longer terms of medical education for licensure. Then followed laws, worked for assiduously, establishing hospitals for the indigent sick, sanitation and quarantine rules, and restrictions on the sale of narcotics.

But Dr. Sutherland wanted more. He urged the MSMA and its Committee on Legislation to press for laws requiring all children to be vaccinated before starting school and enabling the State Board of Health to compel reporting of births, deaths and communicable diseases. He wanted a bacteriology lab at the State Board of Health and for that entity to have authority over county health officers so an epidemic beginning in one part of the state might be contained before spreading.

The Association approved resolutions on these subjects along with another to exclude any teachers or pupils with active TB from coming to school. They received a number of scientific papers, including one on the diagnostic and therapeutic value of the X-ray and another on the value of bacteriology in sanitation.

Dr. Sutherland made one final point. The MSMA's membership stood at 458, only one-quarter of the state's doctors. He urged them to recruit the other physicians, because all of the progress he had ever seen made had been accomplished through unity.

The enormity of the consequences of the victories the MSMA has won in the past, to the indisputable benefit of all Mississippians, staggers the imagination. All of the victories were small ones but were built one upon each other. It was hard then, and it is hard now. But the work is worth it.

Leslie E. England, MD
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

FOUNDATION FOR MEDICAL CARE
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COOPERATIVE CARDIOVASCULAR PROJECT UPDATE

The Cooperative Cardiovascular Project (CCP), the Foundation for Medical Care's first national project under the Health Care Financing Administration's new approach to quality improvement for Medicare patients, has been well received by Mississippi providers as it reaches the midway point.

Hospital services provided to Medicare patients with acute myocardial infarction (AMI) over an eight-month period have been reviewed. Some 2500 patient charts from Mississippi hospitals were abstracted to profile patterns of care related to seven clinical indicators chosen from the American Heart Association's Clinical Guidelines for care of AMI.

As of the end of July 1996, hospital-specific and comparative state and national peer group data have been provided to all collaborating hospitals through on-site and regional presentations as well as mailouts to facilities unable to attend the presentations.

Mississippi hospitals have received summary data comparing the usage rates of each indicator therapy in their hospital with aggregates for each indicator in the facility's peer institutions in the state and a national sample. In selective situations, the Foundation has also provided examples of rates in one or more "benchmark" facilities in the state. These "benchmark" facilities are identified as having usage rates near optimal for the indicator being measured.

Collaborating hospitals have been reviewing their data and developing quality improvement plans to improve care for patients admitted with AMI. The majority of hospitals have submitted improvement plans to the Foundation and the remaining facilities are being offered assistance in developing plans to facilitate their continued participation in the project.

Data collected thus far is detailed in the accompanying graphs. The aggregate data show that Mississippi hospital patterns closely approximate those of the national sample except for beta blocker therapy. Ideally, the percentages for each indicator in the "ideal" categories should be approximately 100% for all hospitals both statewide and nationally. Foundation Clinical Coordinator Dr. Alton B. Cobb noted, "We have opportunities for improvement in the care of AMI in Mississippi for each clinical indicator mirroring those existing nationwide. We have an even greater opportunity for expanding the use of beta blocker therapy in patients statewide."

There are several opinions as to why Mississippi hospitals have significantly lower use of beta blockers. Cardiologists differ as to the specific causes but acknowledge that use of beta blockers is lower in the southern region of the nation. Dr. Cobb also noted, "Some physicians may not utilize beta blockers in older patients because of concerns about the potential for negative side effects."

At a recent meeting of the Mississippi chapter of the American Academy of Family Physicians, Dr. William J. Rogers of the University of Alabama Medical Center in Birmingham emphasized that expanded use of beta blockers in selected patients would lower reinfarction rates and reduce mortality.

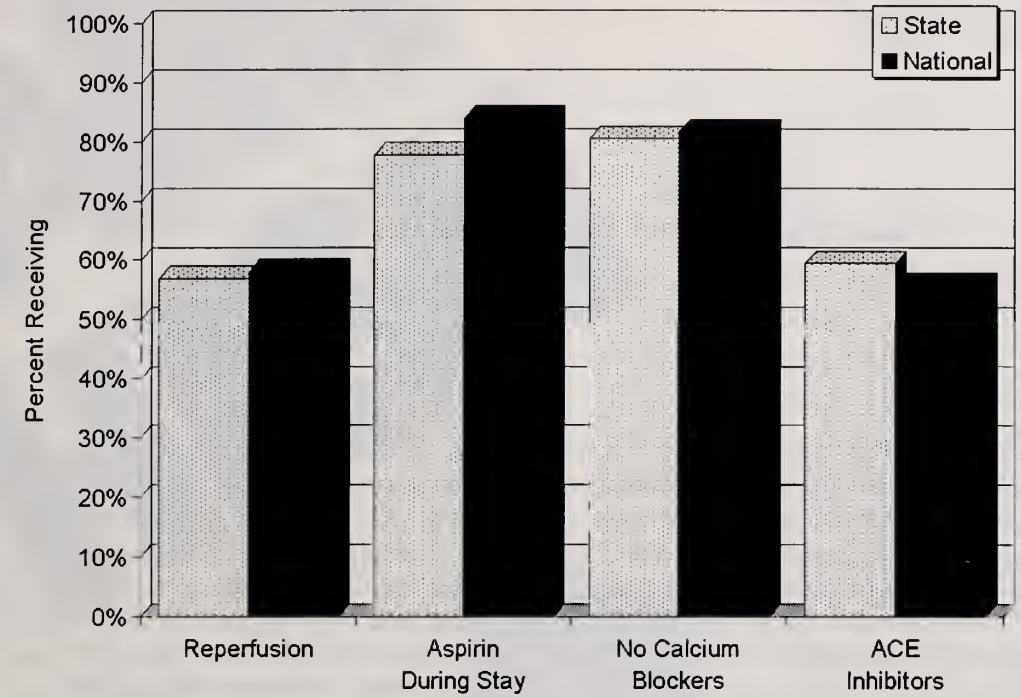
After examining the data trends and submitting their improvement plans, the collaborating hospitals will implement their plans for improving practices and/or processes to achieve a pattern of care for AMIs that will more closely meet the recommended "best practice" guidelines as outlined by the American College of Cardiology and the American Heart Association. Following implementation of improvement plans, each facility will be encouraged to measure changing practice patterns.

Dr. Cobb concluded, "The Cooperative Cardiovascular Project has provided an excellent opportunity for the Foundation and collaborating hospitals to work effectively toward the goal of significantly improving the quality of care for patients admitted to Mississippi hospitals with acute myocardial infarction."

Updates concerning the Cooperative Cardiovascular Project will appear in future editions of the Foundation's newsletter, ***Quality Matters***. Anyone with questions and/or comments concerning the project can contact Foundation CCP staff at 601-354-0304 or 1-800-844-0600.

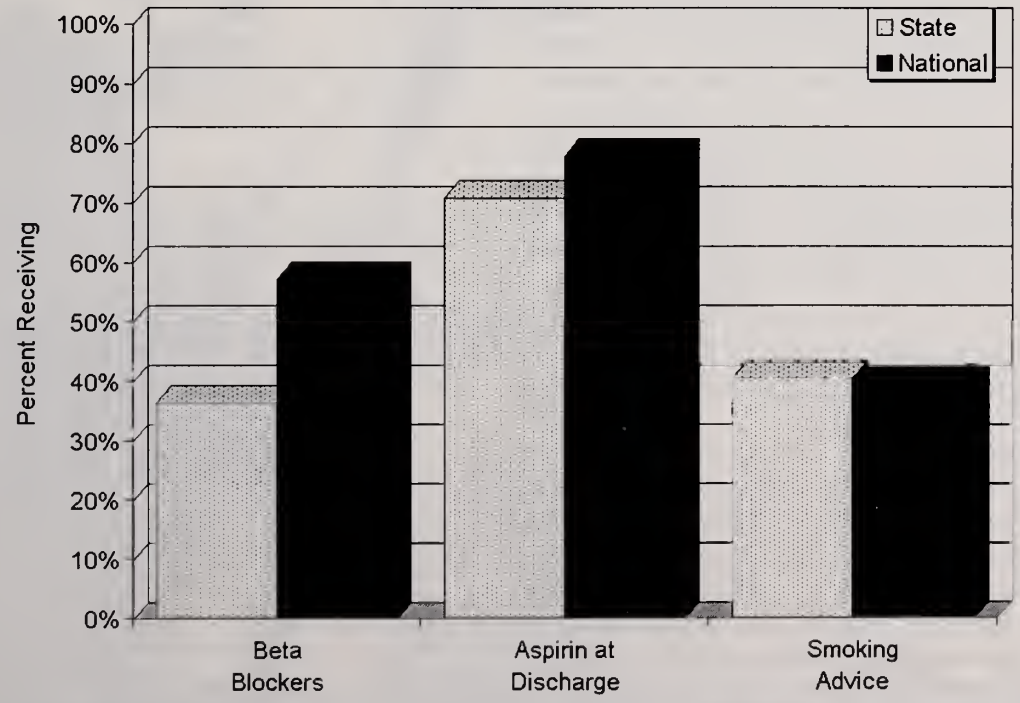
Cooperative Cardiovascular Project Graphs

UTILIZATION OF PROVEN TREATMENTS FOR "IDEAL" PATIENTS



CCP MISSISSIPPI

UTILIZATION OF PROVEN TREATMENTS FOR "IDEAL" PATIENTS



CCP MISSISSIPPI

"Hand in Hand" by J. T. Davis, Sr., M.D.

Travel through the twentieth century and fifty years of medical practice in Mississippi through the reflections of one of its finest and most successful citizens and physicians, J. T. Davis, Sr. Granddaughters, Sallie Kate and Laine Dillingham inspired this book by bringing the author the unwritten pages with a request to fill them. "Tell us about when you were a little boy." "Tell us about when you were growing up." "Tell us about your life."

J. T. accepted this charge. The book is written, published, and available. A book whose first intention was to chronicle a family history has broad appeal. It is both informative and inspirational.

This book shows what an individual with vision can accomplish. Take a dream, combine an indomitable spirit with hard work, care, and concern for others, and stir.

Anyone in or contemplating a career in the medical profession will enjoy this book. A personal experience or that of family or friend with an injury or disease, is frequently a triggering career event. Through his own story, J. T. Davis, Sr. touches on the commonality of us all. The challenges and solutions, agonies and ecstasies, joys and sorrows are those of reality. The characters in this book are genuine people with whom the reader can strongly identify. Through it all, an unwavering, positive attitude, perseverance, and tenacity prevail. It is a book of fulfillment despite some of life's adversities. Today's youth need this clear vision of career attainment and satisfaction in an ever more challenging profession.

Corinth, Mississippi, where J. T. Davis lived and practiced, is representative of small towns and cities across America. The story weaves a personal tale with the history of Mississippi, America, and the development of medical care and practice. It tells the story of the victory of values and virtue, the love of wife, children, family, friends, and patients to a society that needs an inspiration to reclaim these attributes. This is not only a story of personal accomplishment, but one that stresses the importance of "giving back" by service and representation.

The book is quick light reading and fun. Make house calls, grow flowers, build boats, travel, and feel a man significantly touching many lives. This book makes you feel good. It will give your life a boost and a reference point. Perhaps that's what we each need.

Reviewed by Alan E. Freeland, M.D.

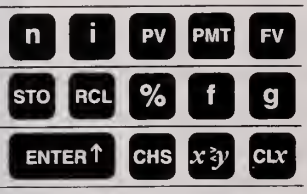
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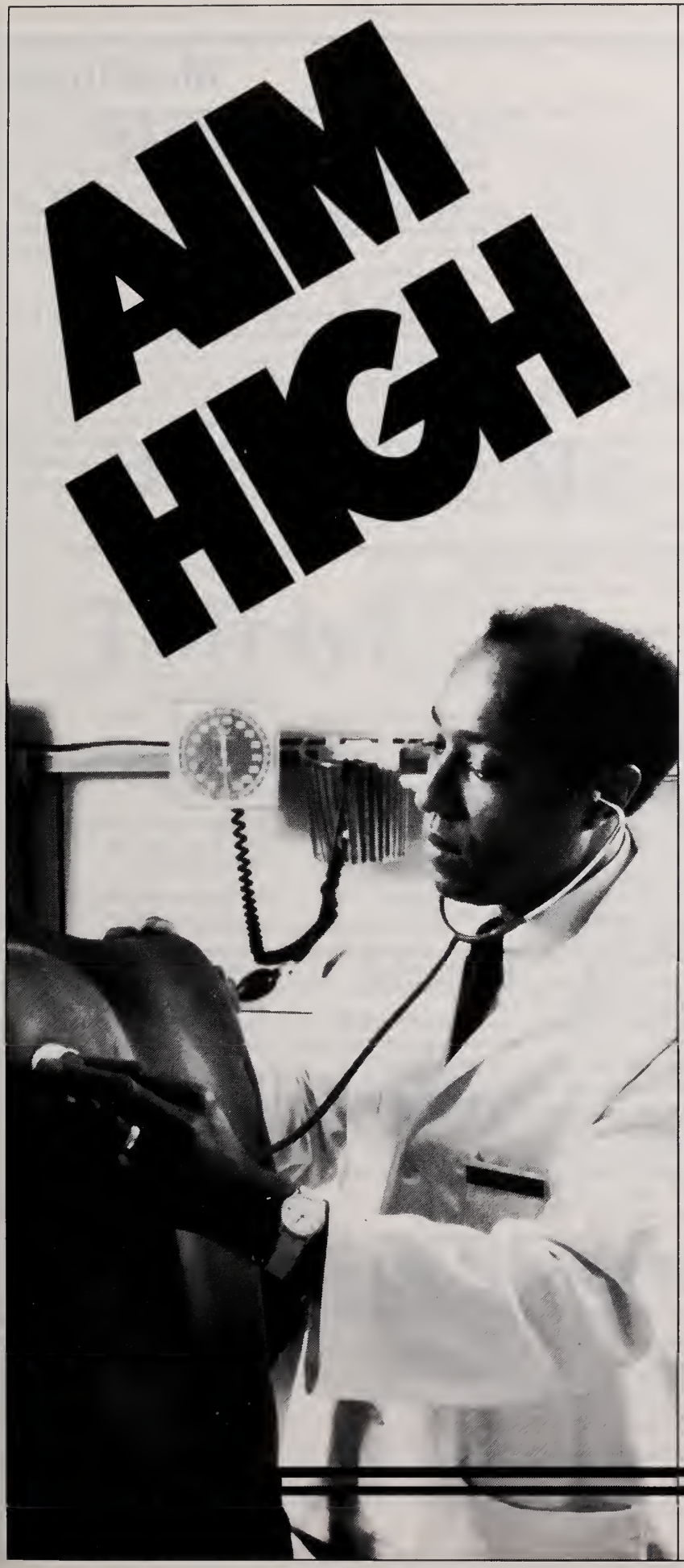
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American Medical Association — *Young Physician Section Assembly*, December 5-7, 1996, Atlanta, GA; *Organized Medical Staff Section*, December 5-9, 1996, Atlanta, GA; *Interim Meeting*, December 8-11, 1996, Atlanta, GA; *Organized Medical Staff Section*, June 19-23, 1997, Chicago, IL; *Young Physician Section Assembly*, June 19-21, 1997, Chicago, IL; *Leadership Conference*, March 16-19, 1997, Philadelphia, PA; *Annual Meeting*, June 22-26, 1997, Chicago, IL; *Interim*, December 7-10, 1997, Dallas, TX; P. John Seward, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

STATE AND LOCAL

Mississippi State Medical Association — Annual Meeting, May 14-18, 1997, Biloxi, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Mississippi Hospital Association/MS State Medical Association - Health Issues Forum, January 15, 1997, Jackson.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, PO Box D, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Mrs. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., Mail: Ms. Leslie Johnson, PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. A. Randle White, MD, Secy., 609 Tallahatchie St., Greenwood, MS 38930. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: PO Box 5025, Meridian 39302. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, J. Chris Hancock, MD, Secy., 46 Sergeant Prentiss Dr., Suite 9, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, Robert H. Curry, MD, 500 A Hwy 9 S, Eupora, MS 39744. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. B. Shane Tucker, MD, Secy., Mail: Ms. Brenda Mabry, PO Box 2180, Tupelo 38803-2180. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, and 3rd Thursday, January. Catherine E. Gleason, MD, Secy., 1308 Belk Blvd., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, William R. Locke, MD, Secy., 107 Doctors Park, Starkville, MS 39759. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Roland Mestayer, MD, Secy., Mail: Mrs. Lujean Trumble, P. O. Box 231, Pascagoula 39568-023. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Jr., MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401-7246. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Daniel Edney, MD, Secy., 1901 Mission 66, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited to Sponsor Intra-state Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited by the MSMA's Council on Medical Education in accordance with the ACCME's "Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education". Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director of Continuing Medical Education at the individual institution or organization.

Baptist Memorial Hospital-Golden Triangle
2520 - 5th Street North
Columbus, MS 39701

Baptist Memorial Hospital-North MS
2301 South Lamar Street
Oxford, MS 38655

Biloxi Regional Medical Center
150 Reynoir Street
Biloxi, MS 39530

Charter Behavioral Health System
3531 East Lakeland Drive
Jackson, MS 39296

Council on Scientific Assembly
MS State Medical Association
735 Riverside Drive
Jackson, MS 39296

Delta Regional Medical Center
1400 East Union Street
Greenville, MS 38704

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

Greenwood Leflore Hospital
1401 River Road
Greenwood, MS 38930

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Gulf Coast Medical Center
180 DeBuys Road
Biloxi, MS 39531

Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

King's Daughters Hospital
Highway 51 North
Brookhaven, MS 39601

King's Daughters Hospital
300 South Washington Street
Greenville, MS 38702

Memorial Hospital at Gulfport
4500 13th Street
Gulfport, MS 39502

Methodist Hospital of Hattiesburg
5001 Hardy Street
Hattiesburg, MS 39404

Methodist Medical Center
1850 Chadwick Drive
Jackson, MS 39204

MS Baptist Medical Center
1225 North State Street
Jackson, MS 39202

MS State Department of Health/
MS Association of Public Health Physicians
Post Office Box 1700
Jackson, MS 39215

Natchez Regional Medical Center
54 Sergeant S. Prentiss Drive
Natchez, MS 39121

North MS Medical Center
830 South Gloster Street
Tupelo, MS 38801

Northwest MS Regional Medical Center
1970 Hospital Drive
Clarksdale, MS 38614

Rush Foundation Hospital
1314 19th Avenue
Meridian, MS 39301

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39581

St. Dominic-Jackson Memorial Hospital
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New Members

Adams, John L., Jackson. Born Chicago, IL, August 12, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1992; medicine intern, Methodist Medical Center, Memphis, TN, one year; anesthesiology residency, Barnes Hospital, St. Louis, MO, 1993-96; elected by Central Medical Society.

Beard, Herman Ray, Jackson; Born Jackson, MS, September 30, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1992; interned and anesthesiology residency, University Medical Center, Jackson, MS, 1992-96; elected by Central Medical Society.

Bennett, James Daniel, III, Columbus. Born Jackson, MS, September 23, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1990; pediatrics residency, University of Arkansas For Medical Sciences, Little Rock, AR, 1990-93; ophthalmology residency, Ochsner Medical Foundation & Clinic, New Orleans, LA, 1993-96; elected by Prairie Medical Society.

Buelvas, Raul Salvador, Jackson. Born Bogota, Columbia, January 14, 1966; MD Medical College of Georgia, Augusta, GA 1992; interned and anesthesiology residency, Mayo Clinic, Jacksonville, FL, 1992-96; elected by Central Medical Society.

Clark, Jeffrey G., Brookhaven. Born Birmingham, AL, October 18, 1962; MD University of Alabama School of Medicine, Birmingham, AL, 1992; surgery & urology residency, University Of Mississippi Medical Center, Jackson, MS, 1992-96; elected by South Central Medical Society.

Gauder, John Wells, Jackson. Born Baton Rouge, LA, May 4, 1967; MD University of South Alabama School of Medicine, Mobile, AL, 1993; interned one year, Carolina's Medical Center; pediatrics residency, University Medical Center, Jackson, MS, 1994-96; elected by Central Medical Society.

Gioe, Scott Michael, Gulfport. Born New Orleans, LA, December 24, 1964; MD Louisiana State University School of Medicine, New Orleans, LA, 1990; internal medicine residency, Ochsner Medical Foundation, New Orleans, LA, 1990-93; gastroenterology fellowship, Ochsner Medical Foundation, New Orleans, LA, 1993-96; elected by Coast Counties Medical Society.

Hartzog, Charles W., Jr., Jackson. Born Dothan, AL, November 4, 1964; MD University of Alabama School of Medicine, Birmingham, AL 1991; orthopaedic surgery residency, Tulane University Medical Center, New Orleans, LA, 1992-96; elected by Central Medical Society.

Herring, Lee Emmett, Jackson. Born Hattiesburg, MS, May 21, 1965; MD University of MS Medical Center, Jackson, MS, 1992; anesthesiology residency, University of Texas Medical Branch, Galveston, TX, 1992-96; elected by Central Medical Society.

Johnson, William Cecil, III, Jackson. Born San Diego, CA, April 5, 1963; MD Tulane University School of Medicine, New Orleans, LA, 1989; anesthesiology residency, Vanderbilt Medical Center, Nashville, TN, 1990-93; elected by Central Medical Society.

Ley, Phillip Blaine, Jackson. Born Needville, TX, August 24, 1960; MD Baylor College of Medicine, Houston, TX, 1988; general surgery residency, Scott & White Memorial Hospital & Texas A & M Health Science Center, Temple, TX, 1989-93; surgical oncology fellowship, University of Texas M D Anderson Cancer Center, Houston, TX, 1993-96; elected by Central Medical Society.

Lindley, Sheila Gay, Jackson. Born Wynne, AR, February 22, 1958; MD University of Arkansas School of Medicine, Little Rock, AR, 1984; interned one year, same; general surgery residency, Creighton University, Omaha, NE, 1985-90; plastic surgery residency, University of Utah Medical Center, Salt Lake City, UT1990-92; plastic surgery residency, Hospital for Sick Children, London, England, 1992-93; hand & micro surgery fellowship, University of Louisville Medical Center, Louisville, KY, 1993-94; elected by Central Medical Society.

Longstreet, Michael, Jackson. Born August 28, 1944; MD Michigan State University College of Human Medicine, East Lansing, MI, 1979; orthopaedic surgery residency, Portsmouth, VA, 1986-89; elected by Central Medical Soc.

McAuliffe, Stephen Wayne, Biloxi. Born Biloxi, MS, October 12, 1949; DO New England College of Osteopathic Medicine 1983; interned one year, Rutgers University Medical Center; family practice residency, Shenango Valley Medical Center, Farrell, PA, 1994-95; elected by Coast Counties Medical Society.

McCain, Reynolds Park, Columbus. Born Tupelo, MS, July 18, 1951; MD University of Mississippi School of Medicine, Jackson, MS, 1981; urology residency, Ochsner Medical Foundation, New Orleans, LA, 1981-84; DEMG fellowship & EEG/Sleep medicine fellowships, Tulane Medical Center, New Orleans, LA, 1/1995 - 6/1996; elected by Prairie Medical Society.

McKillop, Barry A., Jackson. Born Ontario, Canada, July 5, 1949; MD University of Western Ontario, London Ontario Canada 1994; orthopaedic surgery residency, same, 1974-79; elected by Central Medical Society.

McKinney, David Wendell, Amory. Born Tupelo, MS, November 6, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1991; interned one year, Baptist Memorial Hospital, Memphis, TN, 1991-92; anesthesiology residency University of Louisville Medical Center, Louisville, KY, 1992-95; elected by Northeast MS Medical Society.

Mercer, Lloyd Franklin, Jackson. Born Albuqeurque, NM, January 7, 1944; MD Yale University School of Medicine, New Haven, CT, 1969; emergency medicine residency, Hamilton Memorial Hospital, Dalton, GA, 1970-73; orthopaedic surgery residency, Fitz-Simmons Army Medical Center, Aurora, CO, 1981-85; elected by Central Medical Society.

Netherland, Donald Earl, Jackson. Born Jackson, MS, July 25, 1960; MD University of Tennessee College of Medicine, Memphis, TN, 1986; general surgery internship, Portsmouth Naval Hospital, Portsmouth, VA 1986-87; general surgery residency, University Medical Center, Jackson, MS, 1990- 94; thoracic surgery residency, University Medical Center, Jackson, MS, 1994-96; elected by Central Medical Society.

Phillips, John O., Tupelo. Born Memphis, TN, August 22, 1953; MD University of Alabama School of Medicine, Birmingham, AL, 1989; internal medicine residency, Mayo Clinic, Rochester, MN 1989-91; gastroenterology fellowship, same, 1992-94; elected by Northeast MS Medical Society.

Roth, Tracy Y., Pascagoula. Born Lexington, KY, March 27, 1965; MD University of Alabama School of Medicine, Birmingham, AL, 1992; one year internship, Carraway Methodist Hospital, Birmingham, AL; ob-gyn residency, Parkland Memorial Hospital, Dallas, TX, 1993-96; elected by Singing River Medical Society.

Rubin, Mark Jonathan, Waynesboro. Born Brooklyn, NY, November 16, 1965; MD University of South Florida College of Medicine, Tampa, FL, 1991; medicine internship, Alegheny General Hospital, Pittsburgh, PA; anesthesiology residency, Mt Sinai Medical Center, New York, NY, 1992-94; pain management fellowship, 6 months, same, 1/95- 6/95; elected by South Central Medical Society.

Shumaker, Grace G., Jackson. Born Miami, FL, August 17, 1960; MD University of Mississippi School of Medicine, Jackson, MS, 1986; medicine residency, University Medical Center, Jackson, MS, 1988-90; medical oncology fellowship, same, 1990-91; hematology fellowship, University Washington Medical Center, Seattle, WA, 1991-93; elected by Central Medical Society.

Sullivan-Ford, Rhonda K., Jackson. Born February 22, 1965, Hayti, MO; MD University of Tennessee College of Medicine, Memphis, TN, 1992; ob-gyn residency, University of Tennessee Medical Center, Memphis, TN, 1992-96; elected by Central Medical Society.

Walker, Rosalyn C., Jackson. Born Tennessee, June 3, 1960; MD University of Mississippi School of Medicine, Jackson, MS, 1986; interned Tulane Affiliated Hospitals, New Orleans, LA, 1986-87; pediatric residency, University Medical Center, Jackson, MS, 1987-89; pulmonology fellowship, University of Alabama Medical Center, Birmingham, AL, 1989-90; elected by Central Medical Society.

Wilkinson, Brian Lee, Meridian. Born Hattiesburg, MS, May 18, 1965; MD University of Alabama School of Medicine, Birmingham, AL, 1991; surgery internship, LSU Medical Center, Shreveport, LA, 1991-92; pathology residency, University of Tennessee, Memphis/ Baptist Hosp., Memphis, TN 1992-96; elected by East MS Medical Society.

Williams, Kenneth, Holly Springs. Born Pascagoula, MS, May 17, 1960; MD Meharry Medical Col-

lege School of Medicine, Nashville, TN, 1986; internal medicine residency, Wayne St. University Medical Center, Detroit, MI, 1987-89; elected by North MS Medical Society.

Young, Ronald Alan, Tupelo. Born Pontotoc, MS, June 12, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; interned one year family medicine, University Medical Center, Jackson, MS; ob-gyn residency, same, 1992-96; elected by Northeast MS Medical Society.

Fellowship Members:

Field, Mark, Jackson. Born Baton rouge, LA, June 3, 1965; MD Louisiana State University School of Medicine, Shreveport, LA, 1991; orthopaedic surgery, University of South Alabama Medical Center, Mobile, AL, 1991-96; elected by Central Medical Society.

Stollsteimer, George, Jackson. Born Abington, PA, March 6, 1961; MD Temple University School of Medicine, Pittsburgh, PA, 1991; orthopaedic surgery residency, Albert Einstein Medical center, Philadelphia, PA, 1992-96; elected by Central Medical Society.

Deaths:

Hinman, Martin E., Vicksburg. Born Greenwood, MS, July 21, 1926; MD Louisiana State University School of Medicine 1949; interned one year, Charity Hospital, New Orleans, LA; Urology residency, University Medical Center, Jackson, MS, 1958-62; died June 21, 1996, age 69

Wright, Charles N., Jackson. Born September 2, 1926; MD Tulane University School of Medicine, New Orleans, LA, 1952; interned one year; died August 12, 1996 age 69.



Personals

Robert Tibbs, Jr., MD, research associate in neurosurgery, made a presentation at the British Neurosurgery Research Group meeting in Newcastle, England.

Carol Werhan,MD, instructor in anesthesiology, made a presentation at the annual meeting of the Society for Obstetrics Anesthesia and Perinatology in Tucson, Arizona.

William McCluskey, MD, associate professor of orthopedic surgery, made a presentation at the annual meeting of the Pediatric Orthopedic Society of North America in Phoenix, Arizona.

Louis Harkey, MD, associate professor of neurosurgery, taught a course in trauma and tumors in Singapore, Malaysia.

Valee Harisdangkul, MD, professor of medicine lectured in Bangkok, Thailand for the Asian Lecture Program.

Boyd Massey, MD, an ear, nose and throat doctor from Madison was featured in the Clarion-Ledger Sports section "On Golf" for making three hole-in-ones in five weeks at Whispering Pines Country Club in Madison.

James Cook, MD, opthamologist; **Thomas Fenter, MD,** urologist; **Hanley Hasseltine, MD;** ear, nose and throat physician; **Guy Vise, MD; arthritis surgery** and **Wallace Weatherly, MD,** orthopedic surgeon, will provide consultations as specialists for King's Daughters Outpatient Clinic in Yazoo City.

Johnny Ray Bullock, Jr., MD has associated with the Internal Medicine Clinic of Columbia.

Mark Shepherd, MD announces the opening of his medical practice of endocrinology, diabetes and metabolism for adults and children associated with **Sherry Martin, MD** at the Endocrine Clinic.

Albert L. Meena, MD announces his retirement from the practice of general, oncologic, thoracics and vascular surgery with Surgical Clinic Associates, P.A. effective August 1.

Ben Sanford, MD and the Internal Medicine Associates Foundation, Inc. are pleased to announce the association of **Marcus A. Crittenden, MD** for the practice of internal medicine and **William G. Bennett, MD** for the practice of gastroenterology, both in Starkville; **Charles M. King, II, MD** for the practice of rheumatology (referral only), **Charles Hill, MD** and **M. Kevin Smith, MD** for the practice of internal medicine, and **Joe Phillips, MD** for the practice of gastroenterology, all in Tupelo.

Alfred P. Bowles, Jr., MD presented at the annual meeting of the American Association of Neurological Surgeons in Minneapolis, Minnesota.

Silvia Kaufmann, MD is the newest physician on the staff with **Dick Field, MD** at Field Clinic and Field Memorial Community Hospital. Born and educated in Mexico, Dr. Kaufmann is a certified pediatrician through the Board of Pediatrics in both America and Mexico. She also specializes in the treatment of juvenile diabetes and other endocrine diseases in children.

Lara Teal, a third-year medical student at the Bowman Gray School of Medicine of Wake Forest University, is one of two U.S. medical students selected for membership on the Liaison Committee on Medical Education (LCME) of the Council on Medical Education of the American Medical Association and the American Association of Medical Colleges. The LCME oversees the accreditation of U.S. medical schools. Teal is a 1993 graduate of Davidson College. She is the daughter of J. David and Nancy Teal of Jackson.

William M. Wadsworth, MD, internist, joined the family practice of Wadsworth Clinic in Hernando, Mississippi.

Kelly S. Segars, Sr., M.D. of Iuka has received a CAQ in geriatrics as the result of passing an examination administered by the American Board of Internal Medicine and the American Board of Family

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Practice.

Jeffrey N. Evans, MD has been accepted as a fellow of the American College of Chest Physicians. He has also received board certification by the American Board of Sleep Medicine.

James R. Barnes, MD has joined **Dr. Michael L. King** in Oxford in the practice of surgery. Dr. Barnes specializes in laproscopic surgery.

Johnny Ray Bullock, Jr., MD has joined **Dr. Bryan McGraw** Internal Medicine Clinic of Columbia.

Eugene Webb, MD of Greenwood and **John Paul Lee, MD** of Forest have been elected to serve on the Foundation for Medical Care board of directors through 1998.

Jack C. Hoover, MD of Pascagoula is retiring from the delivery room after performing over 5,000 deliveries and supervising about another 500. He will continue to perform surgery and gynecology.

Charles K. Pringle, Jr., MD has joined the Radiological Group, P.A., in Jackson, for the practice of diagnostic radiology and nuclear medicine.

Richard S. Hollis, MD of Amory announces his retirement.

Raymond F. Grenfell, MD, Raymond F. Grenfell, Jr., MD and **Robert M. Evans, MD** announce the association of **Eric M. Dyess, MD.**

Nancy Tatum, MD, assistant professor of family medicine and director of clinical ethics at the University of Mississippi Medical Center (UMC), was selected to participate in the Harvard Macey Institute Program for Physician Educators Sponsored by the Harvard Medical School and the Harvard Graduate School of Education, the program's goal was to enhance the professional development of physicians as educators. The program combined four major themes-learning and teaching, curriculum, evaluation, and leadership. The course provided a select group of 25 physicians with the knowledge and skills to enhance their expertise in both conducting an educational project of their own design and taking a leadership role in the educational activities at their institutions.

William C. Nicholas, MD, associate professor of medicine and director of the general medicine division at UMC, was formally inducted into fellowship of the American Association of Clinical Endocrinologists at the group's fifth annual meeting and clinical congress in Seattle, Washington.

Ann Myers, MD, associate professor of medicine (rheumatology), was invited to serve as a member of the Southeast Region Executive Committee of the American College of Rheumatology. Her term will extend from spring, 1996 through spring, 1999.

Frank W. Bowen, MD, a Carthage physician, received the Mississippi Academy of Family Physicians' highest award at its recent Scientific Assembly held in Point Clear, Alabama. **James R. Weber, MD** of Jacksonville, Arkansas, Past President of the American Academy of Family Physicians was guest speaker. The Family Physician of the Year Award is given in recognition and appreciation for outstanding leadership and services to Family Medicine in Mississippi. This Award was established in honor of the late **Dr. John B. Howell,** longtime member, and delegate to the American Academy of Family Physicians.A native of Memphis, Tennessee, Dr. Bowen entered the private practice of medicine in Walnut Grove, Mississippi, 1952, and moved to Carthage in January 1957. After serving in the U.S. Army 1942-1946, Dr. Bowen received his B.A. from The University of Mississippi in 1948, his B.S. in 1949, his Medical Certificate in 1950, and his Doctor of Medicine in 1951 from the University of Termessee while interning at the Methodist Hospital in Memphis, Tennessee. A primary care physician, he is a Past President and active member of the Mississippi Academy of Family Physicians serving on numerous committees, a member of the American Academy of Family physicians, a Charter Fellow and a Charter Diplomat of the American Board of Family Practice, an active member of the American Medical Association, an active member of the Mississippi State Medical Association, Past President and member of Central Medical Society. He is on the active staff of Leake Memorial Hospital and has served as Chief of Staff on several occasions; presently serves as medical director, Carthage Health Care Center; and medical director of Sta-Home Hospice, Carthage. He is a Past President and member of the University of Mississippi Alumni Association Medical Alumni Chapter, a member of the University of Mississippi Guardian Society, a member of the Dean's Advisory Committee for the University of Mississippi School of Medicine, and a medical preceptor for the University of Mississippi Department of Family Medicine.

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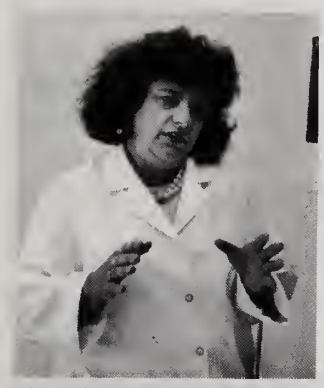
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Nancy Dickey, MD
AMA Board Chair discusses Physician-Assisted Suicide



Photos by: Ted Grudzinski

What is the AMA's overall position on the issue of physician-assisted suicide?

Physicians are devoted to healing and to relieving suffering. As your doctor, I am obligated and committed to helping you in your remaining days. I cannot be the cause of your death, nor can I assist you in causing your own death.

What is the AMA's underlying concern on this issue?

The heart of our concern is placing physicians in the position to actively end their patients' lives. My patients must know wholeheartedly that I am devoted to their health and welfare, not deciding their fate based on what I, or others, might perceive to be the value of their remaining life. Make no mistake, when it comes to caring for my patients' health and welfare, I am their trusted ally.

Does the AMA's Code of Medical Ethics represent all physicians?

Like all individuals, physicians do have a range of personal opinions on various issues. However, the Code of Medical Ethics, which is maintained by the AMA's Council on Ethical and Judicial Affairs, is widely followed throughout the country. It is cited regularly by State Medical Boards when determining standards of practice for the medical profession. In addition, the AMA's House of Delegates reviews and approves all ethical opinions contained in the Code of Medical Ethics. Because the House of Delegates represents, in one way or another, nearly 98 percent of the physicians in America, the Code of Medical Ethics is truly representative of



medicine's position with regard to ethical opinions.

How do you respond to critics who say the AMA's position on physician-assisted suicide does not consider patient fear and desire for dignity at the end of life?

Fear associated with physical suffering, with losing control, with being a burden to or dependent upon family members, and with losing dignity is an understandable reality. The medical profession has not concentrated on these issues to the necessary degree. But, we feel the appropriate alternative to physician-assisted suicide is improved care through a better informed medical profession and public, working together to ease the dying process. I will use all of my skill and knowledge to relieve your suffering, I will get you the help you need to come to terms with death. But, I cannot help you kill yourself.

How does the AMA distinguish between controlling pain even if it causes death and assisted suicide?

The distinction is based on the intent of my actions. I am acting in the best interests of my patient if, while attempting to control suffering and maximize his or her comfort, death is hastened.

However, if the intent of my actions goes beyond comfort and focuses specifically on causing death, I am either assisting in suicide or performing euthanasia, both of which are unethical.

Isn't that a fine line?

In some cases it may be a fine line. Usually, however, the intent is very clear. Regardless, if a line is to be drawn, intent to comfort vs. intent to kill is one line physicians must not cross.



How does assisted suicide through pain medication differ from death caused by removal of treatment/life support?

In the case of a patient whose life is artificially extended by technology, they and their family, in consultation with their physician, may decide to withdraw that life support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy and dignity. Again, the issue is one of intent. By removing artificial life support, I am honoring my patient's wish to allow natural death to occur. My intent is to avoid prolonging artificially-sustained life, not to cause death.

How do you respond to recent court decision in California (9th Circuit), which states that physician-assisted suicide is a Constitutional right?

First of all, nowhere in the Constitution does it state that individuals have a right to have their doctor kill them if they so choose. We find this interpretation to be rather illogical. Second, these and future rulings do not change the ethic of the medical profession which clearly states that physicians should not assist in suicide.

Will the AMA appeal these and other Court decisions?

We will do whatever is necessary to ensure that physicians are not put in a position to kill, and that patients die in comfort and with dignity. If this means appealing directly or submitting amicus briefs or offering verbal



or written testimony in support of an appeal, we will do so. In addition, the AMA is mounting a major information-based campaign to educate and inform the courts, the media, physicians and the general public about the alternatives to physician-assisted suicide, including hospice care.

Will the AMA consider changing its policy regarding physician-assisted suicide?

We will continue our discussions with those whose opinions differ from ours. We will aggressively increase our efforts to educate physicians at all levels in treating physical pain and the psychological needs of patients at the end of life. We will work diligently to enlighten patients on the alternatives to physician assisted suicide, including hospice care. However, the related ethical opinions developed by the AMA's Council on Ethical and Judicial Affairs will remain unchanged.

How does the AMA feel about the $10 million defamation suit brought against you by Jack Kevorkian.

Let's make a distinction here. Notwithstanding our position on physician-assisted suicide, Jack Kevorkian's actions are reprehensible. Even most proponents of physician-assisted suicide are appalled by his activities. Abandoning bodies in parking lots falls well short of our societal expectations for death with dignity. With regard to the lawsuit, we feel that it is nonsense. We will not be silenced on an issue so critical to the welfare of our patients. ◆

Interview by Mark Wolfe

Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

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Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

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Managed Care Contracts...Protecting Your F

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

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Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance compan

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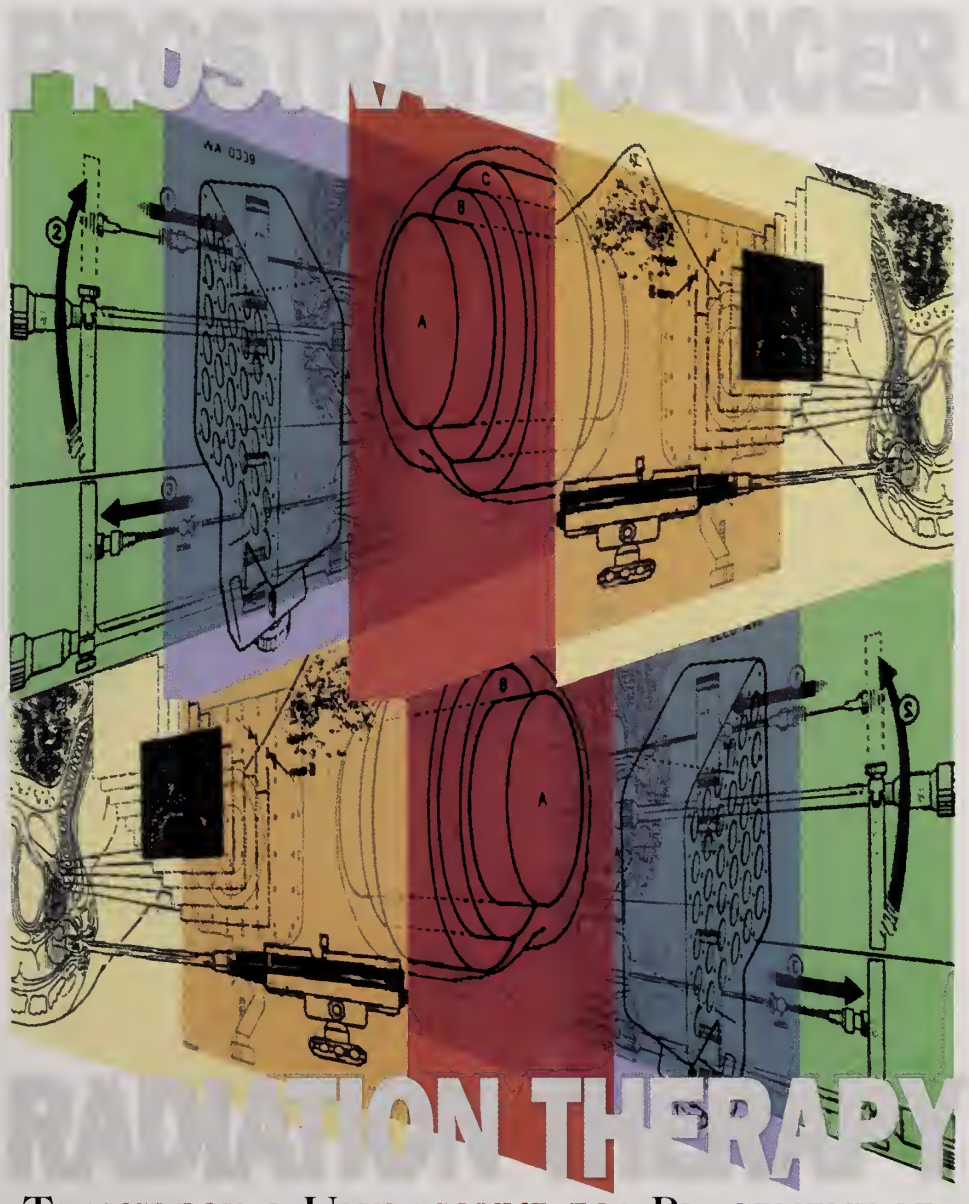
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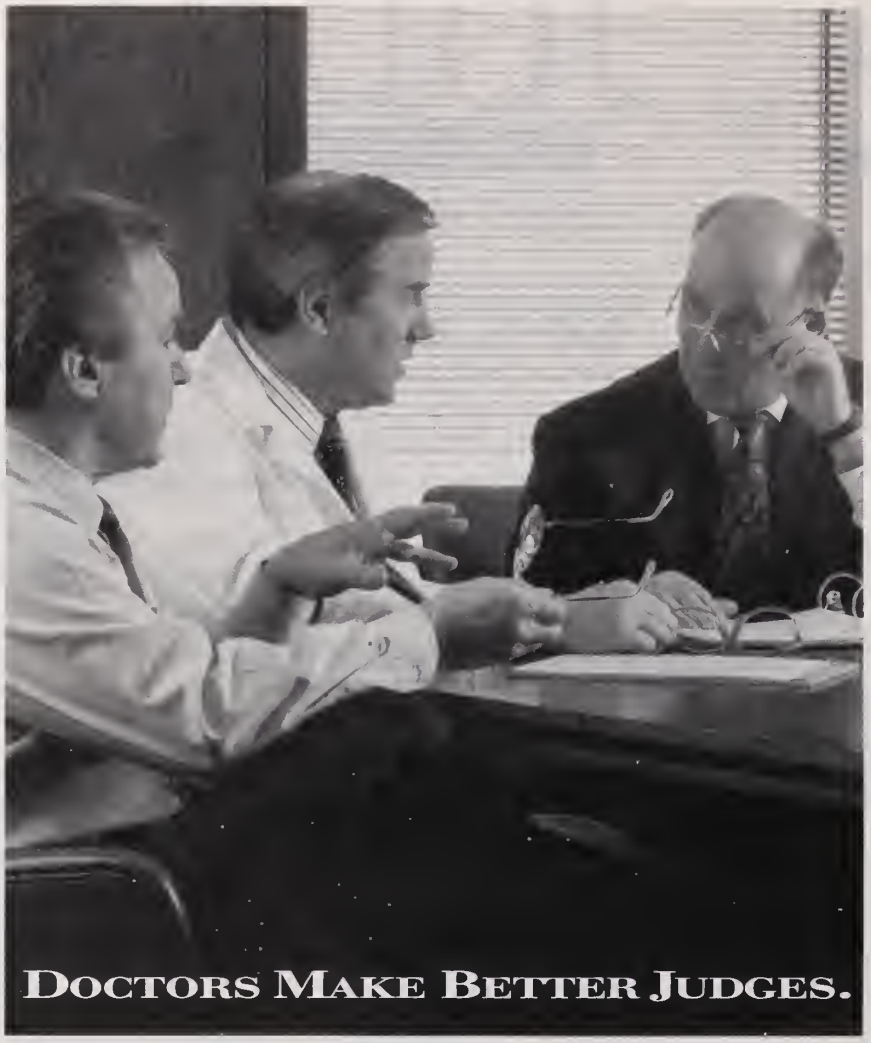
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The Use of Transrectal Ultrasound Placement of Radioactive Seeds for the Definitive Treatment of Prostate Cancer

Steven E. Zachow, M.D.
Robert Hargis, M.D.

ABSRACT:

The definitive treatment of prostate cancer remains controversial although certainly radical prostatectomy is the standard all other treatments must be compared against. However, there potentially can be a multitude of complications as well as extensive hospitalization and costs involved in surgical removal of the prostate gland. The use of radiation therapy in a variety of forms has been proven to be a reasonable alternative. This paper will discuss the use of radioactive seed implants that can be performed transperineally using transrectal ultrasound as a guide. This requires only an overnight stay and appears to provide an excellent chance of a cure with minimal potential morbidity.

The Use of Transrectal Ultrasound in the Placement of Radioactive Seeds for the Definitive Treatment of Prostate Cancer

Prostate cancer in the United States is increasingly becoming a significant health problem for men. The American Cancer Society anticipates that there will be almost 244,000 new cases of prostate cancer diagnosed in 1995.[1] Prostate cancer is the second most common cancer and the third most common cause of cancer deaths in American males.[1] It is estimated by the National Cancer Institute that over 50,000 cases of clinically localized prostate cancer will be diagnosed in the United States. In Mississippi approximately 3000 new prostate cancer cases will be diagnosed. New advances in imaging techniques as well as serum tumor markers including transrectal ultrasound and PSA levels respectively have allowed for earlier diagnosis and more accurate staging of prostate cancer.

At this time the curative modalities for localized prostate cancer remain radical prostatectomy (RP) and radiation therapy (RT). The purpose of this discussion is not to debate the merits of either modality of treatment but rather to discuss a new and updated approach to definitive radiation therapy using transrectal ultrasound and permanent Palladium-103 (Pd-103) seed implant. Both external beam radiation therapy and radioactive seed implant have been in use as a definitive treatment for approximately forty (40) years and over twenty-five (25) years respectively for each form of radiation modality. There has been no adequately randomized study to determine the differences between external beam radiation therapy, radioactive seed implant and radical prostatectomy. Several large institutions have however had many

years of experience with both external beam radiation therapy and radioactive seed implant.[3] Both of which have proved their effectiveness.

The use of radioactive seed implant has generally been confined in the past to usage of Iodine-125 seeds. In the past the Iodine-125 implants required an estimation of the number of seeds as well as blind placement of seeds through an open procedure using a midline abdominal incision. Unfortunately, this often, even under the best of hands, allowed for the seeds to be placed in a less than optimal distribution throughout the prostate gland. In spite of sometimes suboptimal distribution, the ten-year survival for I-125 seed implant for A2 and B lesion is reported at Memorial Sloan-Kettering to be approximately 85% and 60% respectively[2]. When this was sorted out in terms of histology, patients with moderately well or well differentiated adenocarcinoma had a disease free survival at ten (10) years of 70%[2].

The implantation of radioactive seeds therefore is a proven curative procedure for prostate cancer. However, in an attempt to try to optimize the use of the radioactive material as well as provide for more accurate placement of seeds, a variety of changes have transpired over the past five years. The development and refining of transrectal ultrasound has provided a non-invasive means to precisely place radioactive seeds. The rapidly evolving medical-economics may force both patient and clinician to try to utilize the most cost effective form of treatment without compromising a cure. The use of transrectal ultrasound as will be discussed, may very well prove to be the optimal form of definitive treatment for adenocarcinoma of the prostate. This discussion will present the selection, technique and approach to treatment of patients with localized adenocarcinma of the prostate using transrectal ultrasound and Palladium seeds.

An additional problem in implantation of the prostate appears to be the particular isotope that has been used in the past. For most of the patients who have received implantation in the past, radioactive Iodine-125 seeds have been used. Iodine has a relatively long half-life of approximately sixty (60) days. It is very safe to handle, however, because it has a low energy of 28 KeV. Because of this, there is safety in handling iodine seeds, however, biologically there appears to be a relative slow exposure of the surrounding malignancy to the radiation because of the relatively long half-life of the Iodine seeds. A new isotope has subsequently come into the market over the past five (5) years. This is Palladium- 103. Palladium characteristics include also a relatively low energy of 20-23 KeV. However, the half-life of the Palladium-103 isotope is 17 days. Compared to I-125, Palladium-103 delivers approximately four times higher initial dose rate. Palladium is a safe isotope to handle but also biologically appears to be more effective. Long term results from Palladium implantation is not yet available.

MATERIALS AND METHODS

Following diagnosis of apparent localized adenocarcinoma of the prostate implant, the procedure is as follows. Generally, the patient will undergo two sessions. The first session is to perform what is called a grid study or planning session in which the transrectal ultrasound probe is used to provide serial ultrasound pictures through the prostate. The patient is placed in the lithotomy position as if the implantation procedure was planned. At that time, transverse serial sectional images of the prostate are obtained at half centimeter intervals.

During the first session a grid that is to be used to guide the needles at the time of implantation is overlaid on the serial scans. The position is noted such that this is to be duplicated at the time of actual implantation. This grid procedure can be performed as an outpatient and requires approximately an hour of the patient's time (Figure 1).

Following the obtaining of the serial transverse ultrasound pictures of the prostate, the volume of the prostate as well as any possible significant hypoechoic areas that appear to indicate the greatest concentration of cancer are viewed by the urologist and radiation oncologist. At that time the exact volume that is to be implanted is determined. Following this review by the physicians the serial ultrasound sections then undergo computer reconstruction in a three dimensional fashion to allow for longitudinal reconstruction of the prostate

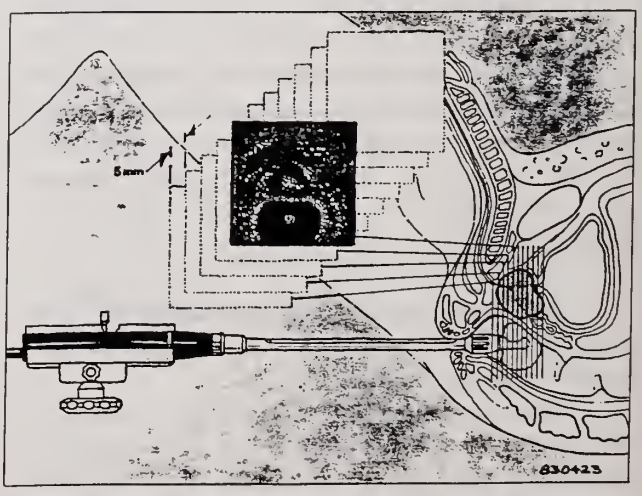


Figure 1-Transrectal ultrasound probe in position with serial ultrasound images being obtained for implant treatment.

gland. This computerized reconstruction of the prostate gland in a three dimensional fashion then begins the actual pre- implantation planning. The purpose of all of this is to allow for an accurate placement of the needles and radioactive seeds in as precise a fashion as possible to maximize the dosage of radiation throughout the prostate gland in a homogeneous fashion (Figure 2,3).

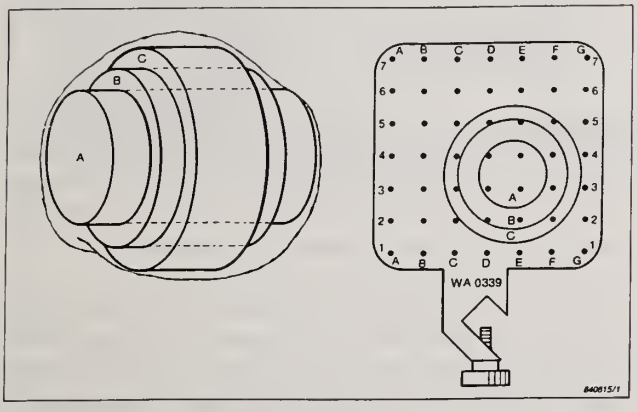


Figure 2-Reconstruction of the prostate in a 3-dimensional view overlaid on the implant template.

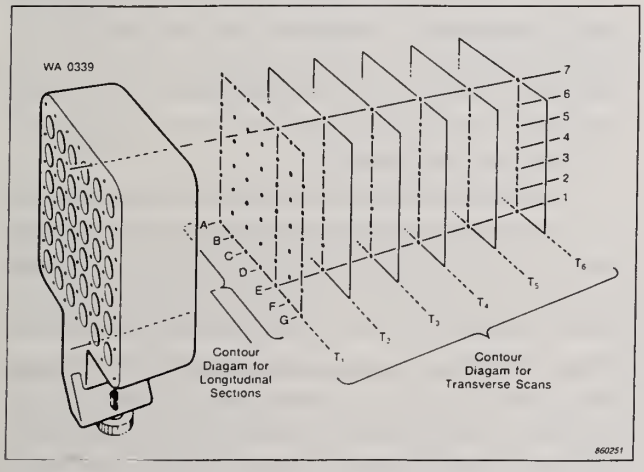


Figure 3-Expanded view of the contour diagram for transverse scans showing the coordinates corresponding with the template for implant.

Using the three dimensional reconstruction a guide map is developed which will precisely pinpoint, using the grid that has been overlaid on the ultrasound, the placement of the transperineal needles and subsequently the Palladium seeds into the prostate gland. In addition, at this time, during the preplanning session, if there are specific hypoechoic areas that appear at greatest risk for a concentration of cancer this allows for the planning of additional radioactive seeds into the hypoechoic area that could serve as a boost to increase the dose of radiation to areas of primary concern.

Following completion of the pre-planning ultrasound and development of an implantation map, the physicians know exactly where each seed will be placed in the prostate. This placement can be reviewed prior to actual implantation of any of the radioactive sources. In addition, one is able to order exactly the amount of radioactive seeds that are needed. There will be no left-over seeds that would increase the cost of the procedure or become a safety hazard.

PROCEDURE

Following all the above noted pre-planning procedures, the second session involving the patient is then scheduled. The patient is generally admitted to the hospital the night before being taken to surgery where the implantation of the radioactive seeds will occur. A lower bowel preparation is performed so that there is no possible interference with the use of the transrectal ultrasound. although spinal anesthesia can be used, a general anesthesia appears to provide better overall control of the situation and stabilization of the patient so there is no unwanted movement. It should be noted that although patients are generally admitted the night before in order to allow for adequate preparation, in certain conditions patients may be admitted that morning as outpatients and end up only staying one night in the hospital. Certainly the economic savings is considerable.

Following anesthesia as noted above, the patient is then placed in the lithotomy position. The transrectal ultrasound is then placed in position after a Foley catheter has been positioned in the bladder. Following positioning of the transrectal ultrasound, an image which duplicates the reference image from the planning ultrasound procedure is obtained. The purpose of this is to be sure the placement of the needles will begin from the precise position from which the planning ultrasound was originally obtained. Following positioning of the transrectal ultrasound the needles are then placed transperineally in a serial fashion. Two needles are initially placed to serve as anchors in order to minimize the movement of the prostate gland when the remained of the needles ar positioned. Currently, we make use of Bruël & Kjaer® transrectal ultrasound probe that allows for transverse, oblique and sagittal pictures to be able to fully document and accurately note the position of each needle both in an anterior-posterior position as well as laterally. The needles are placed from the superior to inferior portion of the gland in a serial fashion with the Palladium seeds loaded a row at a time using a Mick® adapted applicator. The seeds are planned to be one centimeter apart and the

Mick® applicator allows for accurate placement through a guide on the applicator gun (Figure 4). Following placement of all of the needles, the needles are removed as well as the transrectal ultrasound. The room is surveyed to rule out the possibility of any loose seeds either around the perineum, in the needles or in the Foley bag. The patient is taken to the recovery room. The urine throughout the night is saved in the chance that perhaps a seed may be passed out through the urine.

The next morning prior to discharge the patient is brought to the Radiation Therapy Department where x-ray films are taken for dosimetry and treatment planning purposes. The patient has the Foley catheter removed and is able to go home. The patient will then be seen back by both the urologist and radiation oncologist. In general, a follow-up PSA level will not be drawn for approximately three months. Because of the half-life of the Palladium seeds, there will be little risk of public exposure from the radiation. The seeds will have fully dissipated their energy after eight-ten weeks. Biologically, there will be continued effect for 3-6 months with clinical decrease in the size of the gland, softening in consistency and a decrease in PSA level.

RESULTS

Since we have begun using transrectal ultrasound and Palladium seeds for the treatment of adenocarcinoma of the prostate, seventy-five (75) patients have been implanted. All seventy-five (75) patients have undergone the procedure as note previously in the article. Only one patient who had received previous external beam radiation therapy approximately ten years prior to the finding of recurrence had Palladium seed implant. This patient, unfortunately, had hemorrhage from the bladder and subsequently expired due to cardiopulmonary arrest. The remaining patients who have been implanted have had no permanent complications from surgery and have done well thus far. The only transient problem following the procedure has been urethritis. Long term complications, such as incontinence and impotence have not been seen, but should be much less than surgery or external beam treatment. Each of the patients are followed on a three to six month basis by the radiation oncologist and urologist. PSA levels are drawn in a similar time frame. If the PSA or physical examination is noted to change, then repeat diagnostic ultrasound is obtained as well as biopsies of any suspicious areas noted on the ultrasound. There have been six patients who have been found to have persistent disease on follow-up ultrasound. All of these were noted on the follow-up ultrasound to have a mild elevation of the

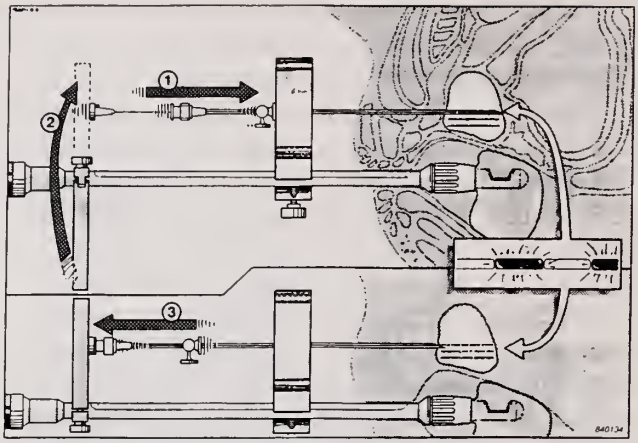


Figure 4- The implant needle is in position in the prostate under direct transrectal ultrasonic guidance. The seeds are left behind after the needle is withdrawn.

PSA level following the initial decline. Each of these patients were able to be re-implanted. That is, on follow-up ultrasound the patients were noted to have a "cold" area generally at the apex of the gland. These patients underwent re-implantation with additional seeds placed into this presumed cold area. All the patients tolerated this re-implantation procedure well and have had no undue problems. They are currently being followed and thus far are doing well. None bf-the patients have died of the disease and none, thus far, have developed clinically evident metastatic disease.

In summary, the use of transrectal ultrasound and implantation of Palladium seeds appears to be a viable and successful approach for the treatment of localized carcinoma of the prostate. In those men who have multiple medical problems and are not felt to be candidates for radical prostatectomy or are concerned by the possible side effects of surgery or external beam radiation therapy, Palladium seed implant is a reasonable and worthwhile alternative for the patient to consider. Long term follow-up from the use of Palladium seeds is not known but should be at least as good, if not better, than use of Iodine seeds for implantation of adenocarcinoma of the prostate[4,5]. It is anticipated that long term results should be much improved over previous Iodine seed implants because of the improved dosimetry and technique allowing for better distribution of the seeds. The improved technique and use of the Palladium isotope will, hopefully, have a greater biological effect. The procedure can only be unconditionally recommended as a primary procedure due to the lack of a long term result. However, the five year data demonstrates local control approaching 100% with normal PSA and no local recurrence[6]. We would anticipate, however, this particular procedure should prove to be effective as a cure for prostate cancer as well

as a cost effective approach to dealing with localized adenocarcinoma of the prostate.

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The Effect of Levenogesterol (Norplant®) Contraception on Coagulation as Measured by Antithrombin-III Levels

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Abstract

Purpose: To determine the effect of contraception given immediately postpartum on coagulation as measured by antithrombin III.

Study Design: In this prospective study, parturients (n = 85) self selected three means of postpartum contraception: levenorgesterol implants, oral contraceptives, or a barrier method.

Results: Baseline coagulation was assessed by antithrombin-III levels in each of the 85 women within 48 hours of delivery (100.35 ± 1.61%) and at one (109.1 ± 1.89%) and six (105.51 ± 1.71%) weeks postpartum. There was a rise in antithrombin-III after delivery but there were no significant differences between the groups.

Conclusion: The levenorgesterol implant system did not cause a decrease in antithrombin-III in normal parturients.

Key words: Norplant®, postpartum, coagulation, antithrombin III

Introduction

The ideal contraceptive device would be one that is usable in the early puerperium since this period is when many unintended pregnancies occur, particularly in the adolescent age group. Levenorgesterol (Wyeth-Ayerst, Philadelphia, PA) subdermal implants are an effective method of contraception because of the high rate of compliance since it does not require user motivation and because one insertion lasts for several years.[1] While it is safe and efficacious, problems include a high incidence of breakthrough bleeding and subsequent patient-requested removal. Another serious potential problem might its effect on coagulation as other forms of hormonal contraception are associated with hypercoagulability, thus, their use in the very early postpartum period is controversial.[2] A frequently-used test of increased risk of hypercoagulability is the antithrombin-III (AT-III) test. We selected this screening test of coagulation because of its prior use in women taking birth control pills, also the test is readily available, relatively low in cost, and is more sensitive when compared to other markers for alterations in the profile. Any decrease into the range of <50% AT-III activity represents a clinically significant risk for thrombosis.[2]

The purpose of this study was to measure AT-III levels in women utilizing an early puerperal implantable contraceptive device as well as hormonal or barrier birth control methods.

Table 1

AT-III Response Levels

	Contraceptive method			
	Oral	Subdermal	Barrier	P value
Beginning of study				
Patients evaluated	38	25	22	
AT-III level*	101.18 ± 2.64*	99.75 ± 2.71	99.59 ± 2.90	0.897
End of first week				
Patients evaluated	38	25	22	
AT-III level	109.74 ± 3.49	107.76 ± 2.85	109.54 ± 2.48	0.899
End of sixth week				
Patients evaluated	12	17	22	
AT-III level	99.33 ± 4.88	107.00 ± 2.79	107.73 ± 2.03	0.143

*% activity as mean (± SEM) for normal nonpregnant population.

Materials and Methods

Over a six-month period, patients undergoing delivery were allowed to choose between a combination oral contraceptive (ethinyl estradiol 0.03 mg/norgestrel 0.3 mg) pill (OCP), the subdermal levenorgesterol implant, or barrier contraception (condoms, foam, or diaphragm). All women had uncomplicated pregnancies with vaginal delivery using regional or local anesthesia. Phlebotomy into 3.8% sodium citrate (Vacutainer®, Becton Dickinson, Rutherford, NJ) in 1 part citrate to 9 parts whole blood was used to determine AT-III levels on the day of discharge and, at seven days after delivery, and at six weeks postpartum. Platelet-free plasma was obtained by refrigerated centrifugation, stored in iced racks and processed within four hours of collection. At-III activity was measured indirectly by the partial inhibition of excess thrombin method. The residual thrombin is quantitated by its ability to cleave the synthetic substrate H-D-CHG-Gly-Arg-pNA. The release of the chromophore p-nitroaniline by thrombin was measured kinetically. The results are reported as percent normal activity of a standard population (Antithrombin III Chromogenic Assay, Baxter Diagnostics, Inc., Deerfield, IL). The results are reported as percent normal activity mean (± SEM) of a standard population. The chromogenic assay was performed on an MLA Electra-1000C automated coagulation instrument. The University of Mississippi Medical Center hospital reference range is 65-140%. Comparisons between the treatment groups were conducted using analysis of variance (ANOVA). Significance was set at 0.05 level.

Results

During this six-month period, 85 patients elected to enter this study and returned for at least one postpartum evaluation. Of these women, 38 selected OCPs, 25 received subdermal implants, and 22 used barrier contraception. The ethnicity, age, parity, and gravidity were similar between the groups.

There was no significant difference in the initial AT-III level between the groups (P = 0.897) with values averaging 100.35 ± 1.61% mean (± SEM) activity (Table 1). At the end of the first week postpartum, a significant rise to 109.1 ± 1.89% occurred, but AT-III levels were virtually identical in the three arms (P = 0.899). At the six-week follow-up, levels were obtained from 51 patients and had stabilized at 105.51 ± 1.71% mean activity. Again, there was no significant difference between the three groups (P = 0.143). While the levels were statistically similar, those in the OCP group fell after the first week to average 99.33 ± 4.88 at 6 weeks after birth. This level was consistently lower than the other two groups when samples at this time period were compared.

Discussion

These data reveal that the level of AT-III activity as a measure of risk for hypercoagulability was not changed by the mode of postpartum contraception. Particularly, the levenorgesterol subdermal implants which continuously release small amounts of the progestin, levonorgesterol, did not affect the AT-III levels. It has been shown that AT-III levels <50% activity are associated clinically with adverse thrombotic events.[2] While none of the levels were near this clinically significant

range, it is interesting that AT-III levels among patients who chose OCP fell faster and farther than those using implants or barrier contraceptive methods (not statistically significant). It is not surprising that the levenorgesterol implants group reacted in a similar manner to those who used barrier contraceptives. The amount of progestin released from this system is similar to the "mini-pill" and has much less clinical effect than progestins in the combination-type birth control pills. Based on these data, it appears that the use of the subdermal implant system does not affect coagulation as measured by AT-III levels and these devices can be safely inserted during the postpartum period.❑

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Medical Professional Liability: Predictability of Claims

There has been much debate on the interpretation of a physician's claims experience. It has been argued that a physician's past claims experience predicts future experience and that claims experience is related to quality of care provided. The purpose of this report is to provide an overview of articles that examine either the predictability of malpractice claims or the relationship between a physician's liability experience and quality of care. The studies reviewed yielded mixed results on the predictability of claims. Furthermore, the relationship between claims experience and quality of care was not firmly established.

These findings have implications for the National Practitioner Data Bank that was established by Title IV of the Health Quality Improvement Act of 1986 (P.L. 99-660). Operational since September 1, 1990, the purpose of the data bank is to monitor physicians' claims experience. All payments made in settlement or judgment on behalf of a health care practitioner named in a written complaint about the care and/or services rendered must be reported to the data bank. Organizations such as hospitals, health maintenance organizations and group practices can access the information and use is to judge the quality and competence of individual physicians (US Department of Health and Human Services 1994).

I. Medical Malpractice Claims: Are They Predictable?

A relationship between past and future claims experience was found by many of the studies reviewed in this report. However, the interpretation of this finding varied from study to study.

Findings on claim predictability include:

• An analysis of a malpractice data base from the Florida Medical Professional Liability claims file showed that past claims experience was found to predict future experience and past payments were found to predict future payments. Nearly half of the physicians who incurred very high payment claims in the period 1975-1980 incurred claims with payment in 1981-1983 (Sloan 1989).

• Examination of claims data from the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that the hypothesis that past claims were a valid measure of an individual physician's future claims experience could not be rejected (Venezian 1989).

• Data from the Medical Inter-insurance Exchange of New Jersey, a physician-owned, medical society-sponsored malpractice insurer covering approximately 70% of the physician malpractice market statewide were examined. Claims filed between 1988 and 1989 were analyzed. On average, physicians incurring large numbers of negligence claims in the past were found to be more, likely to incur large numbers in the future. However, according to the authors, predictions about individuals based on past claims experience are probably not accurate enough to identify most claims-prone physicians (Rolph 1991). Claims closed between 1975 and 1988 were obtained from the Florida Medical Professional Liability Claims file and analyzed. In Florida, a physician's early claims history was statistically related to subsequent claims history; having any claims, whether paid or unpaid, small or large, single or multiple, put a physician at substantially higher risk of having subsequent claims (Bovbjerg 1994).

• Analysis of Oregon state medical malpractice claims showed that having a claim in the previous year doubled both the likelihood of a claim in the following year and the likelihood that a claim results in a payout. The risk of a claim was found to increase following an initial claim, particularly in the subsequent year. Risk management education courses were found to have limited success in reducing claims and payouts and then only following an initial claim (Gibbons 1994).

II. Relationship Between Claims Experience and Quality

While there is some evidence that a physician's past claims experience foreshadows future experience, it is unclear whether claims experience is indicative of the quality of care provided by the physician. Several studies examined this issue and found the following:

• Board certification, a measure of quality, was found to be associated with a higher claims rate. However, board certification may have measured the complexity of care provided by the physician and physicians with high payments may have provided more complex procedures. It was concluded that the empirical evidence did not demonstrate a relationship between claims experience and physician quality (Sloan 1989).

• Efforts to eliminate physicians with large numbers of claims may impact physicians who are simply more active rather than not competent. Because of the wide variation found in the claims experience of physicians across different specialties, policies that are not specialty specific would restrict practice of very large fractions of some specialties while leaving other specialists unaffected (Venezian 1989).

• Florida obstetricians, practicing in 1987, who lost, settled, or defended malpractice claims between 1977 and 1983 were analyzed. The results indicated that using claims experience to identify physicians at risk of future clinical errors may lead to misjudging the likelihood that substandard clinical care will be provided by physicians (Entman 1994).

• Claims against physicians insured by the Medical Inter-Insurance Exchange of New Jersey over the period 1981-1983 were examined in an effort to identify potentially preventable sources of medical injury in obstetrics/gynecology, general surgery, anesthesiology, and radiology. Patient management errors, including errors in diagnosis, medication errors and unnecessary treatment, were found to be the most frequent type of errors committed. These errors, compared with technical performance and coordination problems, were found to be associated with greater morality and higher indemnity payments.

It was concluded that malpractice data could be used to identify problem-prone clinical processes and suggest interventions that may reduce negligence, (Kravitz) 1991).

• Claims filed in New Jersey and closed during the period 1977 to 1991 were used to determine whether the large variation in malpractice claim experience across specialties could be explained by differences in physician performance. Physician performance was assessed using two criteria: The presence of a plaintiff award and whether the physician's patient care was considered indefensible by the physician's insurance company. Despite large differences in claims frequency, most specialties were found to have similar percentages of awards and indefensible cases. Variation in claims rates by specialty resulted from factors other than differences in physician performance (Taragin 1994).

III. Summary

Although there was some disagreement on interpretation of the results, most of the studies summarized here found some correlation between past and future claims experience. However, as noted in one study, there is a big difference between knowing that physicians are more likely to incur claims and being able to identify who those physicians are. Among characteristics of physicians found correlated with claims experience, specialty was the most often cited. Most of the studies found no significant relationship between claims experience and the quality of the provider.

Some of the studies expressed concern about the potential uses of the National Practitioner Data Bank. Some studies warned that Data Bank information could not reliably be used to identify physicians likely to make errors. One study noted that linking physicians' malpractice experience with their quality of care would require more information than could be derived from a closed claim data set. Examples of data necessary to perform such an analysis included information on patient-physician relationships and practice-specific information regarding procedure and patient mix.

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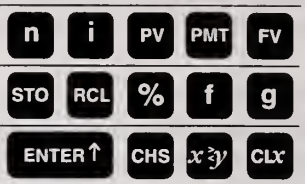
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Fred L. McMillan, M.D.

The President's Page

Making A Difference

In a previous article I spoke of unity and its necessity in order for physicians to regain the leadership role in the delivery of health care. I also spoke of how we must overcome our competitiveness, our short-term, individual goals, and our inter- and intra-community, and inter-specialty rivalry.

In order to once again assume the central role in health care, we must again assume the full risk of the cost of a patient's health care. At the present the health care plan is skimming off ten to twenty percent of the employers' premium payments while leaving us with eighty percent of the risk.

In the past, before Medicare, Medicaid, and other third party payors, physicians assumed the full risk of the cost of a patient's health care. In most instances charges were based on a person's income, and even then collection of the bill was not assured.

The trend over the past decade has been toward cost control-now to the point that quality has become an issue. Employers as a whole are not going to want to sacrifice quality-they do not want their employees unhealthy and therefore unhappy and inefficient.

Physicians are the ones who have the expertise in quality of care. We did not keep control of the cost of care because we did not timely see it as an issue. We have a window of opportunity now to re-establish ourselves as the credible leaders of health care delivery by assuming the full risk of the cost of patient care, and at the same time, assuring the quality of health care. The issue would be value, not cost.

Physicians have always managed care, but in the past patients rationed care by their willingness to pay for it. Their rationing may not have always been based on value or to use the modern term *cost effectiveness*. The patient may not have had an elective operation,

i.e. a sinus sub-mucous resection because of the short-term cost; however, in terms of lost efficiency secondary to recurrent sinusitis the procedure would have paid for itself many times fold.

Now rationing is being done by third party payors because they are assuming the monetary risk. If physicians assume the risk while assuring the quality, we will control the destiny of medical care.

Medicine is a way of life. The more control physicians exert over that way of life the more comfortable physicians will be and the more physicians will feel that they are really helping patients. The more satisfying that way of life will be.

This is being accomplished through State Medical with MPCN, through specialty societies banding physicians together, and through smaller groups of physicians forming at risk groups. Long term caution must be exerted so that physicians maintain ownership and not cash out by selling the equity interest on the open market.

To quote Ronald Reagan, "The very key to our success has been our ability...., to preserve our lasting values by making change work for us, rather than against us." We have an opportunity to make a difference.

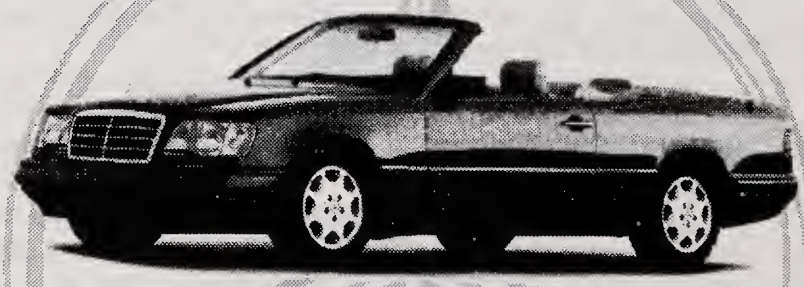
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Editorial

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Become Politically Proactive

Historically most physicians have been apolitical. In the 1950's and 1960's few physicians were openly involved with politics. There were no established rules against doing so, it was just something physicians did not do. In contrast to professionals in other fields physicians were bound by the nature of the practice of medicine. One had to be personally available to administer care, and therefore it was impossible for the physician to leave the practice with his employees, or defer treatments in order to attend meeting and rallies. Medical care administration was relatively stable with the doctor-patient relationship the center of focus. In this scenario physicians found it unnecessary to get significantly involved in politics. Those active in politics during that time generally did so because of close friendships with particular politicians, not because of issues.

The introduction of Medicare in 1966 caught physicians working within the old practice patterns. Although a few became politically active following the introduction of Medicare, they were in the minority. Most continued their old apolitical habits. The extent and variety of changes seen over the past thirty years are directly related to that apathy. Acknowledging that every change could not have been prevented one has to believe that some could have been significantly altered.

All of this leads to a significant situation in the current state of political affairs in the State of Mississippi. I am referring specifically to the elections to the Mississippi Supreme Court, scheduled for November 5, 1996. Allowed to continue unabated in its current mode the State Supreme Court will more profoundly, and adversely, alter the way medicine is practiced Mississippi than by all other activities over the past thirty years.

The only way to affect the court is through the ballot box. It is therefore imperative that physicians in this state do everything possible to favorably impact these elections. Review the materials received from your Association and other sources, look at the record of decisions already rendered by the current court that have profoundly altered the way we practice medicine, and actively participate in efforts to replace those responsible for these decisions. Do not wait until November 5th; start now and discuss these problems with your family, associates, patients, golfing partners, fishing and hunting friends, and others. There is no other way to bring about change in the court except through the ballot box. Rest assured that those pushing for the status quo are not inactive. The Political Action Committees will not be able to do this for you, you have to participate. Become politically proactive.

Myron W. Lockey, MD
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

RETHINKING THE THREE R'S

One of the first things that Beth and I do after being away from home for several days is to grab the latest edition of Kosciusko's weekly newspaper to catch up on local happenings.

On returning recently from the AMA meeting in Chicago where local newscasts reported the abduction from a neighborhood playground and the subsequent sexual molestation in a nearby alley of a seven year old boy (with my cynical reaction, "That's Chicago for you!"), I was shocked to read in the *Star Herald* that an eighth-grader brandishing a handgun was wrestled down at our city pool after threatening swimmers.

Elsewhere in the newspaper, more than half of some ten birth announcements involved unwed mothers. While we take pride in Attala County's low infant mortality rate, our work is obviously cut out as far as our teenage pregnancy rate is concerned.

As I have grown older (and with grandfatherhood on the horizon), I have become increasingly sensitized to matters violent and immoral. Further reflection has caused me to search rather quixotically for remedial measures for the salvation of future generations.

With apologies to fellow alliterist Bill Gates, I was struck with the possibilities of REPUDIATION, RE-EDUCATION, and RECAPITULATION in this regard. As highly visible civic and church leaders, physicians should seize every opportunity to repudiate those life styles which glorify violence, substance abuse, and sexual promiscuity by serving as role models especially for the children and youth of our communities.

As respected professionals, physicians have the unique opportunity (and responsibility) to re-educate the public in general and our patients in particular regarding the impact of lifestyle choices on health. Such opportunities range from spontaneous one-on-one encounters at the time of athletic physicals to more formal presentations to civic, school, and church groups. The AMA, our specialty societies, and organizations such as the American Heart Association stand as excellent (and eager) resources for such efforts.

As effective communicators, physicians must, as we do on a daily basis with instructions to our patients, recapitulate or repeat ad infinitum the principal points of our message. It is only by reiteration and reinforcement that perhaps our words and actions will be heeded.

Stanley Hartness, M.D.

IT'S THE SAME

It's almost the same when a patient dies as with a loved one. That is, at this point of my career when a patient dies that I've treated for thirty plus years there are similar grief reactions. Death and dying as a subject has been well taught over the years. But I did not expect to encounter or experience this grief phenomenon in such a personal way with patients.

Even as a young physician there was the deep sorrow and great compassion for the family with the loss of a family member, but apparently these long term relationships have resulted in a gradually deeper sense of attachment. I am sure every physician has felt the same emotion. There is not the requisite to be relatively old oneself or have treated patients for thirty years, because the bonding that inevitably occurs between patient and physician develops at varying rates, but surely grows over the years and may be deep and lasting.

One observation only realized in recent years is what I have learned from some patients — aspects of philosophy, principle, dedication, responsibility, and understanding. Of course, these have been absorbed from many patients over the years, yet there are remembered specific instances of reaction that have endured.Mixed into these encounters are some adverse reactions, but for the individual who has now succumbed to the forces of death, there is frequently a fondness for some aspect of life that I sense was learned from them. In a few instances I remember exactly what I was taught, whether intended or not.

Are all physicians supposed to reflect, at least to some degree, upon the association developed with a patient who has died? Post mortem examinations and peer review committees critique the medical aspects of death cases. Where is the solace needed though for the physician who has lost — lost physically a patient, and lost emotionally another human who has depended upon medical advice for years and years. And from where will this learning come in the future? If the lesson was not learned at the time, will it come into focus in the future?

There will always be patients, as long as we ask to be put in this awesome position in life of advising other humans as to their health and welfare. And we should listen, to their complaints, praises, and ordinary comments. From these we should learn important meanings of life. Although a huge and monumental burden to bear, the lessons gleaned from responsibilities of caring for patients are precious and invaluable.

Hardy B. Woodbridge, M.D.

AN OPEN LETTER TO "THE BEST BOSS EVER"-PHYSICIAN, NOW HEALTH CARE PROVIDER, FOLLOWS NEW RULES

I have had many jobs over the years. Some were good, most were not so good. But still there were lessons to be learned.

I chopped cotton and plowed during the spring and summer through elementary school for parents who were sharecroppers, and then during high school my parents were actually able to rent acreage to farm. When we finished our duties I would work doing the same for neighbors. Most of what I did is obsolete because at this time it is done with machinery.

We always took a two-week break during the hottest part of the summer and used a crosscut saw to cut wood for the year for cooking and heating. Then, we would pick cotton.

I served three years as a corpsman during the Korean Conflict. I then had a job making cabinets, all by hand. I worked in a steel foundry and put together steel segments that were combined to build barges. I'm sure that the major workers still have helpers.

Common to every job was one critical lesson: Even the less-skilled worker quickly learned to identify the boss.

But that isn't an easy assignment for physicians today. Our patients once were our bosses, but that has changed.

What follows is a thank you note to my old boss. You are welcome to read it.

Dear Patient:

I really enjoyed working for you. Unfortunately, my job has changed.

While health care providers are assigned, a doctor was chosen. You selected me for my skills, training, ability, affability and availability. You worked with me and invited me into your family. You elevated me to a position much higher than I deserved. My weaknesses were recognized, and accepted as examples of human frailty. All you ever asked was that I do my best and that I care. I felt the need to supper with you, and I had many opportunities to share your joy as well as your grief, as we worked together to restore your health.

I won't pretend that working for you was easy. You exacted from me a great price in time, commitment, and responsibility. I was held responsible for your well-being and that of your children. You took some of the time I might have spent with my family. In return you gave me love, respect, power and money. You were a great boss.

Then my job changed. I get up at the same time and do many of the same things. I go to more places, but they are nice places to work. Part of the problem now is job security, or the lack of it. When I worked for you, we both knew you could fire me, but we shared a strong bond that sustained us.

I am not sure who I work for now. My checks still come from the same place, but I know I have a different boss. When I worked for you, you could tell me about a problem, and I would tell you about a solution I thought might be effective. If we could not find a solution, we could suffer together.

I thought it worked well, and I believe you agreed. I am told, however, that your employer has decided we can no longer afford to do our job in the old way. We are spending too much money. I understand American industry can't remain competitive with such high health care costs.

So now I am a health care provider. My new boss, I think, is an insurance company or managed care organization. Maybe I will be on your company's list of acceptable providers. At least I will get to work with you, not for you. It is important now that I deliver just the services specified in the contract, just the right number of visits, and in just the approved facility.

Our technology has advanced at such a rapid rate that I find it difficult to keep up with all the new operations and equipment available for taking care of you. Now I have to know what hospital - oops! - facility I can use and how long you can stay there. Since doctors likely have trouble managing the business of health care, it is fortunate that we will be able to install several layers of administratively trained individuals to help us. Isn't it comforting to know that increasing the number people necessary to take care of you will actually lower the cost? I am sure I could better understand if I had been educated in economic theory.

You were the best boss I ever had. Thanks for everything you did for me. I am going to miss working for you.

-Chester W. Masterson, M.D.

Dr. Masterson is a guest columnist for the ***The Vicksburg Post*** *from which this was reprinted. He is a Fellow of the American College of Surgeons and has practiced in Vicksburg about 30 years. Dr. Masterson is with the Eye, Ear Nose & Throat Clinic on Mission 66.*

Survey: In the Wake of Primary Care Physicians' Income Boosts, Some Specialty Physicians' Incomes are Again On the Rise

St. Louis, MO—As a result of managed care, nationwide shortages of primary care physicians, escalating demand, and the Medicare payment reform plan (resource-based relative value scale or RBRVS) of 1992, primary care physicians' incomes are once again on the rise. On the other hand, specialists who have experienced significant income declines in the past, are now experiencing a stabilization or boost in annual income, according to the Physician Compensation and Production Survey: 1996 Report Based on 1995 Data.

Primary care physicians (family practitioners, internists, and pediatricians) whose incomes increased 7 and a half percent in 1993 followed by a meek 2 and half percent increase in 1994, earned an average 4 and a half percent increase in 1995. At the same time, some specialists who experienced income declines between 5 percent and 20 percent in 1993 followed by income boosts between 1 percent and 7 percent in 1994, are now enjoying income increases of 5 percent to 13 percent in 1995. However, in contrast to primary care physicians' 4 and a half percent increase specialty physicians as a whole earned only a 2 percent increase during 1995.

The annual survey, which includes compensation and production information from more than 1,300 group practices and 28,000 physicians and mid-level practitioners, was conducted by the Medical Group Management Association MGMA, Englewood, Colorado, with funding from Cejka & Company.

Primary care winners as reflected in 1995 median compensation:

Family practitioners—up 6 percent from $122,000 to $129,148
Internists—up 4 percent from $133,581 to 139,320
Pediatricians—up 2 percent from $126,401 to $129,085

"These figures reflect the growing influence of managed care, capitation[1], the necessity to control costs, and the powerful impact of the resource-based relative value scale, all which depend on primary care physicians," says Sue Cejka, President of Cejka & Company.

"These figures are consistent with the trend to shift overall patient care from high cost specialists to low cost primary care physicians," she says. "The end result is an increase in compensation for primary care physicians and a stabilization or decrease in compensation for some specialists. However, because managed care is still a minority in the healthcare marketplace, some specialists' incomes will continue to increase significantly in a fee-for-service environment."

Contrary to their primary care counterparts, pediatricians are once again at the low end of increasing primary care incomes. In 1994, pediatricians experienced a less than 1 percent increase in compensation. "Although 1995's increase doubled for pediatricians from 1994, their annual compensation may continue to increase slowly as healthcare organizations concentrate on specialties that are more versatile, such as family practice," adds Cejka.

Ms. Cejka concedes that in an era of managed care, primary care physicians who were once at the low end of the compensation scale, are now in an excellent position to make more money than they ever would have in a fee-for-service environment. "For many physicians, the very nature of managed care and capitation is taboo. They see this as a move by industry to cut incomes and constrict autonomy. But as primary care becomes the center of healthcare delivery, primary care physicians are quickly learning how capitated patient panels and managed care environments can lead to significant annual income boosts," says Cejka.

[1]Capitation: A payment method used in managed care environments to control costs. Under capitation, unlike fee-for-service (FFS) venue is unrelated to charges. A physician or organization receives a fixed revenue stream per patient per month whether the patient needs a cholesterol test or throat culture. Rather than providing increasing or escalating levels of service (FFS) to a patient population, an organization generates profit and retained earnings by increasing the number of patients under its care.

In addition, Ms. Cejka observes integrated delivery systems upping the compensation for primary care physicians in order to recruit and retain these highly valued practitioners. "Primary care delivery is the backbone of healthcare. The success of healthcare organizations will rely on their primary care medical staff. Without a sufficient primary care medical staff, the ability to control costs and provide quality care in a competitive healthcare industry will be impossible."

Specialty Winners

As managed care has yet to impact a lot of markets in the United States, many specialty physicians are still compensated under the traditional fee-for-service plan, resulting in significant income boosts for this group. Some of the winners from 1995 include:

Invasive Cardiologists: Following a 4.2 percent increase in 1994, their compensation jumped 7.6 percent from $313,211 to $337,000.

Noninvasive Cardiologists: Keeping pace with last year's 4 percent increase, their compensation is up 5.4 percent from $227,169 to $239,406.

Dermatologists: Experiencing a 5 percent increase in 1994, their compensation is up 7 percent from $165,009 to $176,948.

Gastroenterology: In the wake of a 2 percent decline in 1994, their compensation is up 4.4 percent from $200,992 to $209,913.

General Surgery: After a 3.3 percent increase in 1994, their compensation is up 8 percent this year from $200,21 1 to $216,562.

Plastic Surgery: On the rebound from an 8 percent decline in 1992 and a I percent decline in 1994, their compensation jumps 14 percent from $199,868 to $227,496.

Financial Losers

As primary care physicians enjoy compensation increases, many specialists are feeling the impact of healthcare reform and their gatekeeper colleague's financial success.

Anesthesiologists: Subsequent to a 6 percent increase in 1994, their compensation dropped 2 percent from $244,600 to $240 666 in 1995.

Radiologists: Following a boost of 3 percent in 1994, compensation decreased 6.4 percent from $264,446 to $247,505 in 1995.

5 Year Trends

In retrospect, primary care physicians are winning the compensation game. Median compensation for primary care physicians between 1991 and 1995 rose 22.3 percent as median compensation for all other specialties increased only 6 and half percent. This gives family practitioners something to smile about as their median compensation rose 22 percent between 1991 and 1995, while invasive cardiologists' median compensation increased 8.7 percent during this same period.

Jim Smith, FACHE, CMPE, Senior Vice President of Cejka Healthcare Consulting, predicts compensation for primary care physicians will continue to increase steadily due to their emerging role as "gatekeepers" under managed care. "While they'll never be paid like cardiologists or cardiovascular surgeons, their compensation will reflect the pivotal nature of the gatekeeper role in an integrated delivery system," he says. "As the system shifts its focus to health promotion and prevention, internists who once earned as little as $90,000-$100,000, will have opportunities for continued increases in the future."

Life After Training

New primary care physicians, who are undoubtedly looking forward to their important roles in healthcare delivery, will be happy to know that their compensation in their first 2 years of practicing medicine is not too far behind the national median. The median compensation for a new family practitioner is $108,925, up 8 percent from last year and only $20,000 less than the national median for all family practitioners.

However, in 1994 median compensation for new family practitioners increased only 1 percent. This reverse trend is affecting internists and pediatricians whose incomes significantly increased in 1994, but both dropped in 1995.

"It's part of the compensation pendulum," says Smith. "Last year new family practitioners' incomes slipped and this year the new pediatricians and new internists are seeing their incomes take a hit. The increase this year for family practitioners can be attributed to the age diversified patient panel the family practitioners serve, while pediatricians and internists are limited to age specific patient panels. This makes the family practitioners more marketable as healthcare organizations recruit primary care physicians, resulting in compensation boosts necessary to lure family practitioners to their practice," concludes Smith.

Male vs. Female Physicians

Last year's survey revealed male primary care physicians earning between $17,000 and $25,000 more than female primary care physicians. Despite the growing demand for woman physicians—especially women obstetricians and gynecologists, the 1996 report reveals that male physicians are still earning a considerable amount more than female physicians. The median compensation for a male family practitioner was $131,268, compared to $112,089 for female family practitioners, according to the survey. Other disparities include:

Specialty	Male	Female	Difference
Internal Medicine	$14,3552	$119,088	$24,464
Psychiatry	$136,048	$122,869	$13,179
Dermatology	$181,863	$158,673	$23,190
Ob/Gyn	$224,369	$192,800	$31,569
Pediatrics	$137,065	$119,660	$17,405

Growth for Mid-Level Providers

In light of the increasing demand for primary care "gatekeepers" more expansive roles for mid-level providers, particularly physician extenders, are on the horizon. These professionals, who in some cases can deliver up to 70 percent of the care some primary care physicians deliver, are joining forces with primary care physicians to form healthcare teams composed of a physician, physician assistants, specialized nurse , social worker, nutritionist, or public health aide. Due to continued shortages in many of these professions, median compensation levels for these professionals rose significantly in 1995. Among those earning highest incomes:

Nurse anesthetists: Up 12 percent from $72,001 to $80,469
Nurse mid-wives: Up 7 percent from $56, 682 to $60,606
Nurse practitioners: Up 2 percent from $48,157 to $49,200
Physician assistants (surgical): Up 4.7 percent from $53,751 to $56,264
Physician assistants (primary care): Up 5 percent from $51,368 to $53,963

The ***MGMA Physician Compensation and Production Survey: 1996 Report Based On 1995 Data***, can be obtained through the MGMA at 303-397-7888. The survey covers in detail over 50 physician specialties and over 14 mid-level provider specialties in the following areas:

•Direct Compensation by specialty, group type (single specialty/multispecialty), number of FTE physicians, at risk managed care percent of revenue, method of compensation, geographies, years in specialty, gender, and hospital practice affiliation.

•Retirement Benefits by specialty and group type.

•Compensation to Production Ratio by specialty, group type, and years in specialty.

•Production by specialty, group type, number of FTE physicians, at risk managed care percent of revenue, geographies, years in specialty, and gender.❑

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SUCCESSFULLY SEDATING *- (left to right) Adine Piediscalzo, MRI technician, Dr. Gary Smith, director of off-site anesthesia, and Earl Coleman, clinical technical director, provide a new anesthesia service, allowing more patients to receive sedation and pain relief during medical procedures at the University of Mississippi Medical Center in Jackson.*

UMC Adds New Off-Site Anesthesia Department

A new service provided by the Department of Anesthesiology at the University of Mississippi Medical Center in Jackson allows more patients to receive sedation and pain relief during medical procedures.

Anesthesia personnel, under the supervision of Dr. Gary Smith, director of off-site anesthesia, sedate "special needs" patients having painful or invasive procedures in various departments such as MRI, CT scan, special procedures, adult lithotripsy, and the Children's Cancer Clinic.

Procedures or studies such as those done in MRI may not be painful, but require the patient to remain motionless. Some patients, nonetheless, have difficulty lying still. Other procedures like bone marrow harvests and lumbar punctures can be painful.

In some cases, children and adults who are particularly anxious about the procedures become difficult to manage only with local anesthetics.

"We do sedate children, but we're not always successful," explains MRI technician Adine Piediscalzo. "Adults often become claustrophobic, and that makes it difficult to sedate them. With the new services, the patients feel secure, and we can predict what's going to happen. Everything runs like clockwork."

Personnel in other departments are allowed to administer a standard amount of sedative medication, without the assistance of anesthesia personnel, but sometimes an increased dosage is needed. Before the new anesthesia service was initiated, the procedure was simply rescheduled or canceled altogether if a patient required additional medication. "There was no set pattern, and we never knew if we would be able to complete a MRI scan on a patient. It's good to

know that now we can get the scans done," she said.

The off-site services were initiated about three years ago in MRI when Dr. Smith was an anesthesiology resident at the Medical Center.

"We have simple monitoring devices and have refined our procedures to become more mobile without sacrificing safety for the population that we serve. It's a very compact, self-contained means of safely serving many patients."

Clinical technical director Earl Coleman agrees: "We provide the same quality of care a patient receives in the operating room, with full monitoring and the same vigilance."

The two say that the services performed by the Department of Anesthesiology have been welcomed by other departments as well as the patients and their relatives.

"If persons in the department have tried to sedate a patient and are having difficulty, we're prepared to administer as much sedation as needed," Dr. Smith says. "We know that the studies need to be done, and once our services have been requested, we strive to help complete those studies."

"In addition," Coleman adds, "we're able to relieve a lot of the staff's apprehension and the fear felt by the patient, especially if it's a child." "The kids don't want to hurt, and the parents don't want hurt. We feel the amnesia and pain relief we provide makes an unpleasant experience a tolerable one."

"A lot of the patients don't remember anything about the procedure, and many don't even remember us being there. That's exactly the effect we want," Dr. Smith said. "Personally, there's a certain amount of satisfaction that comes with knowing that we can help relieve the pains and fears of our patients. At the same time, we're developing a very workable rapport with personnel from other departments because we have one common goal: to benefit the patients of the University Hospitals and Clinics."

Dr. Smith also noted that UMC's off-site anesthesia has peaked the interest of the state medical community.

"I've had several physicians contact me, asking for our opinions on starting similar services at their facilities," he said. "We're working toward becoming a resource for other facilities that may be considering offering this type of service."

"There was no set procedure for offering these services, but we've developed one that's hopefully a prototype for others to follow."

"We've had to work out a lot of technical difficulties, and we've been able to acquire the equipment needed to provide quality services," Coleman says.

Physicians' Recognition Award



Twelve MSMA members were named recipients of the AMA Physicians Recognition Award in August 1996. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Medical Society
Albert B. Britton, MD
Donald Grillo, MD
Richard Earl Rhoden, MD
Mickey Paul Wallace, MD

Clarksdale and Six Counties Medical Society
Richard Edwin Waller, MD

Coast Counties Medical Society
Thomas Earnest Benefield, MD

North Mississippi Medical Society
Pravinchandra P. Patel, MD

Northeast Mississippi Medical Society
Tom B. Longest, MD
John David Seay, MD

Prairie Medical Society
George Leroy Howell, MD

South Mississippi Medical Society
Adron Keith Lay, MD
John Paul Lee, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Foundation for Medical Care Liason Committee Serves Special Purpose

A committee charged with coordinating information sharing efforts for Medicare and Medicaid beneficiaries meets regularly at the Foundation for Medical Care and includes representatives from a variety of agencies and organizations with similar interests in beneficiary outreach.

Known as the Beneficiary Liaison Committee, its members work to identify and maximize the use of appropriate communication methods.

Committee members help develop strategies for the improvement of communications with beneficiaries in the areas of health promotion, quality of care, disease prevention and their rights under Medicare.

Methods for dissemination of health information throughout the state are discussed by committee members who meet primarily with the Foundation's Communications Department staff. Influenza immunization, stroke and mammography information have been the highlight of educational efforts in recent months.

"Sharing important information with beneficiaries and their caregivers demands strategic planning in order to maximize our efforts in the state," said Dr. James S. McIlwain, principal clinical coordinator. "The input from the Beneficiary Liaison members enables us to make the best use of materials, time and staff."

As the discussion of health care issues continues, the need for networking among various organizations to share information increases. Now meeting four times a year, the committee has added members and also calls special focus meetings when forums, seminars and workshops on vital topics are scheduled.

"The contribution and support of this group are pivotal to the Foundation in its mission of sharing information," said Dr. McIlwain. "As more information continues to come from the Health Care Quality Improvement Program, this committee will play an important role in exploring the best ways and means for maintaining beneficiary awareness."

The Committee includes:

J. L. (Jake) Scott, Foundation Board of Directors, AARP representative
Nell Wiygul, AARP, Consumer Representative
Ivory Craig, State Coordinator, MS Division of Aging & Adult Services, MS Ins. Counseling & Assis tance Program
Kay Farmer, State Advocacy, AARP
Kay Foster, Blue Cross & Blue Shield of MS, Medicare Part A
Dianne Catledge, Blue Cross & Blue Shield, Medicare Part A
Lynn Muha, MetraHealth, Medicare Part B
Dr. Dorothy Idleburg, Tougaloo College Gerontological Program Director
Judy Goddard, Consumer Management Specialist, Consumer Money Management Center;
George Hardy, LCSW, Consultant, Home and Community-Based Services, MS State Health Department
Billie R. Phillips, MSNRN, University of Mississippi School of Nursing
Dr. Deirdre McGowan, Executive Director of various allied health associations
Linda Patterson, Health Education Specialist, Cooperative Extension Service
Roy Mitchell, Program Coordinator, MS Health Advocacy Program ❑

-James S. McIlwain, M. D.
Principal Clinical Coordinator

Meetings

NATIONAL AND REGIONAL

American Medical Association — *Young Physician Section Assembly*, December 5-7, 1996, Atlanta, GA; *Organized Medical Staff Section*, December 5-9, 1996, Atlanta, GA; *Interim Meeting*, December 8-11, 1996, Atlanta, GA; *Organized Medical Staff Section*, June 19-23, 1997, Chicago, IL; *Young Physician Section Assembly*, June 19-21, 1997, Chicago, IL; *Leadership Conference*, March 16-19, 1997, Philadelphia, PA; *Annual Meeting*, June 22-26, 1997, Chicago, IL; *Interim*, December 7-10, 1997, Dallas, TX; P. John Seward, MD, Executive Vice President, 515 N. State St., Chicago, IL 60610

STATE AND LOCAL

Mississippi State Medical Association — Annual Meeting, May 14-18, 1997, Biloxi, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Mississippi Hospital Association/MS State Medical Association - Health Issues Forum, January 15, 1997, Jackson.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, PO Box D, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Mrs. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., Mail: Ms. Leslie Johnson, PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. A. Randle White, MD, Secy., 609 Tallahatchie St., Greenwood, MS 38930. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: PO Box 5025, Meridian 39302. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, J. Chris Hancock, MD, Secy., 46 Sergeant Prentiss Dr., Suite 9, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, Robert H. Curry, MD, 500 A Hwy 9 S, Eupora, MS 39744. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. B. Shane Tucker, MD, Secy., Mail: Ms. Brenda Mabry, PO Box 2180, Tupelo 38803-2180. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, and 3rd Thursday, January. Catherine E. Gleason, MD, Secy., 1308 Belk Blvd., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, William R. Locke, MD, Secy., 107 Doctors Park, Starkville, MS 39759. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Roland Mestayer, MD, Secy., Mail: Mrs. Lujean Trumble, P. O. Box 231, Pascagoula 39568-023. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Jr., MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401-7246. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Daniel Edney, MD, Secy., 1901 Mission 66, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited to Sponsor Intra-state Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited by the MSMA's Council on Medical Education in accordance with the ACCME's "Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education". Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director of Continuing Medical Education at the individual institution or organization.

Baptist Memorial Hospital-Golden Triangle
2520 - 5th Street North
Columbus, MS 39701

Baptist Memorial Hospital-North MS
2301 South Lamar Street
Oxford, MS 38655

Biloxi Regional Medical Center
150 Reynoir Street
Biloxi, MS 39530

Charter Behavioral Health System
3531 East Lakeland Drive
Jackson, MS 39296

Council on Scientific Assembly
MS State Medical Association
735 Riverside Drive
Jackson, MS 39296

Delta Regional Medical Center
1400 East Union Street
Greenville, MS 38704

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

Greenwood Leflore Hospital
1401 River Road
Greenwood, MS 38930

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Gulf Coast Medical Center
180 DeBuys Road
Biloxi, MS 39531

Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

King's Daughters Hospital
Highway 51 North
Brookhaven, MS 39601

King's Daughters Hospital
300 South Washington Street
Greenville, MS 38702

Memorial Hospital at Gulfport
4500 13th Street
Gulfport, MS 39502

Methodist Hospital of Hattiesburg
5001 Hardy Street
Hattiesburg, MS 39404

Methodist Medical Center
1850 Chadwick Drive
Jackson, MS 39204

MS Baptist Medical Center
1225 North State Street
Jackson, MS 39202

MS State Department of Health/
MS Association of Public Health Physicians
Post Office Box 1700
Jackson, MS 39215

Natchez Regional Medical Center
54 Sergeant S. Prentiss Drive
Natchez, MS 39121

North MS Medical Center
830 South Gloster Street
Tupelo, MS 38801

Northwest MS Regional Medical Center
1970 Hospital Drive
Clarksdale, MS 38614

Rush Foundation Hospital
1314 19th Avenue
Meridian, MS 39301

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39581

St. Dominic-Jackson Memorial Hospital
969 Lakeland Drive
Jackson, MS 39216

MSMA & MSMAA Health Promotions Proposal

In hopes of decreasing violence and preventing violence-related crimes and tragedies in Mississippi, the Mississippi State Medical Association Alliance Health Promotions Committee in conjunction with the Mississippi State Medical Association and the American Medical Association Alliance have launched a program called SAVE: STOP AMERICA'S VIOLENCE EVERYWHERE! The program is an extension of the Campaign Against Family Violence which was developed by the AMA Alliance in 1991. SAVE will be a year-round program with the goal of making an impact on the devastating social problem that robs so many Americans of quality living.

The second Wednesday in October has been designated as the annual SAVE Today! Alliances across the state will be encouraged to implement at least one program to call attention to SAVE Today. Possible programs for SAVE may be as simple as getting the local mayor to proclaim October 9 as SAVE Today, a poster contest or distributing information to school children, or highway billboards with the SAVE message. Other programs could include educational seminars, walk-a-thons, fund-raisers, or candlelight vigils. We also plan to have Governor Fordice sign a proclamation for the State of Mississippi for SAVE Today.

Health Choice '97 will once again be offered to the children of Mississippi. The goal this year is to increase the number of children in attendance at each location. We are encouraging county alliances to involve more children. Selected sites are Winona, Singing River, Vicksburg and Gulfport! JeVon Thompson will once again be our featured speaker expanding on such ideas as anti-violent behavior, conflict resolution and gun safety awareness! Attention will focus on these issues to compliment our theme of SAVE! The tentative dates are March 24 - 28, 1997. It's important to help children grow up understanding that violence is not the answer to life's conflicts!

This year we will include in our health program the DOC program at UMC. Dr. Nancy Tatum and the Family Practice Residents will present the Tobacco Awareness Program. We are excited to be a part of this and to help educate the 5th grade students about the danger of using tobacco.

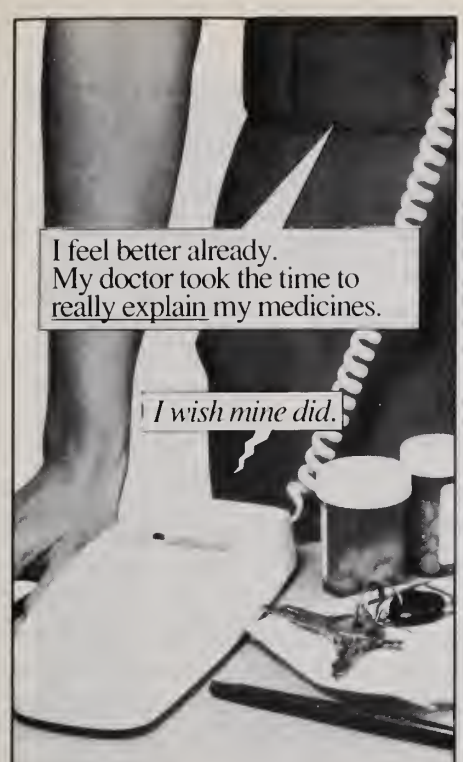
Here again each alliance will be encouraged to implement this program in the method best suited for their area. The component societies will be invited to be a part of this project. Their support, financially or physically, will be appreciated.

Gun Safety Awareness education and project ideas will also be presented to each county. Each alliance will determine how best to conduct the program for their area.

We believe that each alliance will have a strong health project this year. We want to offer health projects in areas of our state where we have no active alliance. We do have willing workers who are members at large.

Thank you for the support of the MSMA. Working together we shall share a successful year.❑

-Nancy Bush
President MSMA Alliance



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Jones County MSMAA Receives Health Awareness Promotion Award From the AMA Alliance For It's "Women's Life Conference"

The hospital in cooperation with the Jones County Medical Alliance decided back in 1989 that the women of the community lacked educational access to health care topics. The hospital recognized this as a problem as well as an opportunity. South Central Regional Medical Center joined forces with the Jones County Medical Alliance in organizing an educational conference devoted totally to women in the community. This educational conference was an effort to better equip women in the community to make the best health care decisions for themselves and their families. After all, we know that women make the majority of health care decisions today, not only for themselves but also for their children, spouse and extended family members.

The initial goal of the conference, fondly known now as the Women's Life Conference was to announce the opening of the Women's Life Center at South Central Regional Medical Center. This "center" is the primary information source in the area for all issues pertaining to women and their families. The offerings of the Women's Life Center are numerous including: a reference library; a lending library of books, pamphlets, audiotapes, and videotapes; ongoing classes and seminars including prepared childbirth, parenting education, babysitter education, and preconception education; a mammogram reminder program, a monthly educational series hosted by the hospital; and a toll-free information line.

The first Women's Life Conference in 1990 was so successful it has become a yearly event. The participation has increased from 150 attendees in 1990 to over 500 attendees this year. The goal has evolved over the past 6 years. It is now a mechanism to say thank you to the community for supporting the local hospital and medical care community as well as a mechanism to address the health concerns and wellness needs of women in the community.

To plan this yearly event, a Women's Health Issues Committee was formed. The current committee is composed of 20 women from the community representing a broad spectrum of ages, interests, education and occupations. Women are appointed to the committee based upon their interest and involvement in the community. The committee has become so involved and excited about the project, that most of the women who served on the original committee are still active in the Women's Health Issues Committee. The Health Promotions Chairman of the Jones County Medical Alliance serves on this committee of women dedicated to planning this yearly conference.

The planning process begins with securing a keynote speaker and ensuring appropriate facilities for the conference. This year it was necessary due to the large numbers of women participating in last year's event to move the location from a local hotel conference facility to the community junior college.

The keynote speaker is chosen after a written survey and follow-up telephone survey is performed among a random sample of the previous conference attendees. The list of names of potential keynote speakers is presented to the Women's Health Issues Committee and recommendations are made. The chairman of the committee begins the process of phoning prospects and securing a speaker based upon these recommendations. Speakers for the Women's Life Conference have included such notable persons as Dr. Joyce Brothers, Mary Ann Mobley, Linda Dano, Dr. Sonja Friedman, Ann Jillian, Naomi Judd, and this year's speaker Suzanne Somers. In Ms. Somer's presentation, "Keeping Secrets," she shared her story of growing up as the child of an abusive alcoholic and the effect it had on her life. The Jones County Medical Alliance was excited about this presentation as it reemphasized the SAVE message and the horrible circumstances that ensue when violence occurs in the home.

After the keynote speaker is confirmed, work begins on planning the breakout educational sessions, a physician panel, health and wellness information booth fair, and the luncheon. Breakout session topics are chosen by surveying past attendees and reviewing evaluation and attendance information from the previous year. Ideas for topics



Humorist Janie Jasin opens the "Women's Life Conference" sponsored by the Jones County Medical Alliance in Laurel, Mississippi. The event, held at Jones County Junior College, won a Health Awareness Promotion Award (HAP) given by the American Medical Association Alliance.

are also generated from the Women's Health Issues Committee. Final choice of topics is decided by the committee and speakers from the local healthcare and wellness community are secured. This years breakout sessions consisted of: 1) Telling Tales: How to Preserve Family Heritage Through Storytelling, 2) Don't Be A Victim: Safety Savvy for Women, 3) The Life You Save... Cancer Facts for Women, 4) Gender Stress: Understanding the Differences, 5) Straight Talk about Hormone Replacement Therapy, 6) Shake, Rattle, and Roll - What's Keeping You from Sleeping? 7) Ease, Lessen, Stop the Pain: Unscrambling Pain Reliever Choices. Each year members from the Health Issues Committee and the Medical Alliance are responsible for monitoring the sessions and introducing each speaker. Additional treats this year included a motivational humorist who opened the conference with a presentation entitled "Enthusiasm: The Light from Within" and the current Miss Mississippi, who entertained the crowd with her wonderful voice.

The physician panel or "Doc Talk" is always a highlight of the conference. This general session involves a panel of local physicians who are available to answer questions posed by conference attendees. This session is well received by physicians who enjoy the opportunity to provide education and encouragement to women.

There is also a health information and wellness booth fair which is available for all women attending the conference to ask questions and gather information from local physician offices and other health care facilities servicing the community. The Medical Alliance always participates in this fair. This year we were able to provide information regarding the SAVE program, offer gun trigger locks, and serve as a liaison for informing women of community resources related to violence prevention and assistance.

The Women's Life Conference has become an annual event which many women in the community look forward to with great anticipation. It is the same time every year, the last Saturday in April. I have heard many women making comments about attending the conference or wondering who the speaker will be long before any official announcement is released. Women in Jones County have come to expect the Women's Life Conference in April every year, just as they expect the 99% humidity every July. Corporate sponsorship for the event has increased dramatically over the years so that the conference is able to advertise in the paper, radio, TV, and on a local billboard. This project clearly represents a symbiotic relationship between the local hospital and Jones County Medical Alliance. The Alliance could never achieve such great success with the Women's Life Conference without the broad support of the hospital. Likewise the hospital could not effectively plan the Women's Life Conference without the input of women in the community such as those represented by the Alliance. We recognize that without each other we would fail, but together we form a mighty team that can't help but achieve its dream.❑



***Kay Gatewood, executive director for the Caduceus Club of Mississippi** and **Ellis M. Moffit, MD, Caduceus Club medical director**, accept a check in the amount of $2,000 from **Eileene McRae, State Board chair for the Impaired Physicians' Committee of the MSMA Alliance.** The contribution to the Caduceus Club was made through the Alliance's fundraising efforts which generate awareness and educate county Alliances on addiction and recovery. For this year's project McRae donated a watercolor painting (shown below) from which the Impaired Physicians' Committee of the MSMA printed note cards for the Alliance to sell. To purchase the notecards contact Kay Gatewood at the Caduceus Club, phone 601-981-3408 or 1-800-844-1446.*

In Family Faces Amy Giust has captured the reality of familial differences where there is conflict. Her talent beautifully illustrates her sensitivity to humankind. This card was printed as a fundraiser to assist families in need. Amy resides in Hattiesburg, Mississippi, with her husband and three children. Her work can be found in several galleries in the Southeast and she is in the process of illustrating her first book.



FAMILY FACES- Watercolor,* by *Amy Giust



Fred L. McMillan, M.D. *made his first visit to a component society since taking office as MSMA president when he addressed the Prairie Medical Society in Columbus. Shown with McMillan (back left are Prairie Medical Society officers* ***William R. Locke, M.D., secretary*** *(back right);* ***Thomas E. Scheffield, M.D., president-elect*** *(front left) and* ***Ronald E. Powell, D.O., president*** *(front right).*



About 100 medical students of the University of Mississippi School of Medicine attended MSMA's annual pizza luncheon to hear ***Dr. Don Q. Mitchell****'s membership recruiting address.*



***Helen Wetherbee, Executive Director of the State Division of Medicaid**, addressed the **Council on Medical Service** August 21. She updated the council on the state Medicaid program including the status of the eleven-county pilot project that utilizes capitated managed care provided by commercial health maintenance organizations. She also discussed recent actions of the Legislature's Joint Study and Oversight Committee on Managed Care.*



*The **Joint Practice Committee** met to review the rules, regulations and statutes that govern collaborative practice agreements between physicians and nurse practicioners.*

New Members

Antwine, Harold M., III, Jackson. Born Jackson, MS, December 29, 1964; MD Tulane University School of Medicine, New Orleans, LA, 1991; orthopaedic surgery residency, Greenville Memorial Hospital, Greenville, SC, 1991-96; elected by Central Medical Society.

Barrow, Vernon W., III, Columbus. Born Starksville, MS, November 4, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1989; interned on year, Baptist Hospital, Memphis, TN; radiology residency, LSU, New Orleans, LA, 1991-92, Baptist Hospital, Memphis, TN, 1992-95; diagnostic radiology, University of Alabama Medical Center, Birmingham, AL 1995-96; elected by Prairie Medical Society.

Berry, Scott M., Jackson. Born Illinois, August 7, 1961; MD, Loyola University Stritch School of Medicine, Maywood, IL, 1989; surgery residency, University of Cincinnati Medical Center, Cincinnati, OH, 1989-96; elected by Central Medical Society.

Billups, William A., III, Meridian. Born Jackson, MS, March 3, 1965; MD University of Alabama School of Medicine, Birmingham, AL 1991; general surgery residency, Parkland Memorial Hospital, Dallas, TX, 1991-96; elected by East MS Medical Society.

Boyte, William R., Jackson. Born Lime Stone, Maine, April 24, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1987; pediatric residency, University Medical Center, Jackson, MS, 1987-90; pediatric Critical Care, University of Tennessee Medical Center, Memphis, TN, 1991-94; elected by Central Medical Society.

Dulske, Michael G., Jackson. Born Detroit, MI, June 30, 1964; MD Texas Tech University School of Medicine, Lubbock, TX, 1990; orthopaedic surgery residency, University Medical Center, Jackson, MS, 1991-95; orthopaedic fellowship, Hahnemann University Medical Center, Philadelphia, PA, 1995-96; elected by Central Medical Society.

Gipson, Walter E., IV, Picayune. Born Marysville, CA, July 18, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1993; family practice residency, University Medical Center, Jackson, MS, 1993-96; elected by Pearl River Medical Society.

Johnson, Wayne, Cecil, Jr., Clinton. Born Memphis, TN, August 23, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1993; family practice residency, University Medical Center, Jackson, MS, 1994-96; elected by Central Medical Society.

Jordan, Terry T., Meridian. Born Charleston, SC, December 10, 1960; MD Meharry Medical College of Medicine, Nashville, TN, 1990; psychiatry residency, Same, 1990-96; elected by East MS Medical Society.

Lampton, Brett C., Magnolia. Born Jackson, MS, July 1, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; internal medicine residency, University Medical Center, Jackson, MS, 1991-93; elected by South Central Medical Society.

Muyot, Aurelio J., Ripley. Born Philippines, October 27, 1964; MD University of the Philippines College of Medicine, Manila, Philippines, 1989; internal medicine residency, University of Illinois Medical Center, Chicago, IL, 1990-93; geriatric residency, University of Tennessee, Memphis, TN & University of Illinois, Chicago, IL, 1993-96; elected by North MS Medical Society.

Spiess, Steven D., Hattiesburg. Born Toronto, Canada, January 8, 1967; MD Dalhousie University School of Medicine, NC, Canada, 1992; elected by South MS Medical Society.

Stanley, Markus B., Vicksburg. Born Conway, AR, July 15, 1957; MD University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1993; family medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by West MS Medical Society.

Wofford, Marion R., Jackson. Born Jackson, MS, January 7, 1956; MD University of Mississippi School of Medicine, Jackson, MS, 1993; internal medicine residency, University Medical Center, Jackson, MS, 1993- 96; elected by Central Medical Society.

Personals

Carol Scott-Conner, M.D., professor of surgery, served as a participant at the American Association of Clinical Anatomists in Rochester, Minnesota. She also served as a participant at the National Institute of health study section in Bethesda, Maryland.

Angelos Halaris, M.D., professor and chairman of psychiatry and human behavior, made a presentation at the Hellenic Society Medical Meeting, The Hellenic American Society of the Health Sciences.

John H. Eichhorn, M.D., professor and chairman of anesthesiology, spoke at the Society of Cardiovascular Anesthesiologists annual meeting and workshops in Philadelphia, Pennsylvania. He was also visiting professor at the State University of New York Health Science Center/Syracuse, and was invited guest speaker at the 5th District meeting of the NYSSA in Syracuse, New York.

Vinod K. Anand, M.D., associate professor and director of the Division of Otolaryngology, was guest faculty at the 19th annual Fitz-Hugh Symposium Fundamentals of Rhinoplasty Combined Program in Charlottesville, Virginia.

Robert Vincent, M.D., associate professor of anesthesiology made a presentation at the Society of Obstetric Anesthesia and Perinatology Meeting in Tucson, Arizona.

Sabra Sullivan, M.D., assistant professor of medicine, was a moderator at the American Academy of Dermatology conference in Washington, D.C.

Emily Ward, M.D., associate professor of pathology, made an oral presentation at the American Academy of Forensic Science in Nashville, Tennessee.

Candice Keller, M.D. has agreed to serve for another year as co-chair of the American Medical Association (AMA) Advisory Panel on Women Physician Issues. The Board of Trustees finalized her appointment for a one-year term through June 1997.

Richard Griswold, M.D., staff member and associate medical director of the department of pathology at North Mississippi Medical Center in Tupelo, has achieved subspecialty certification by the American Board of Pathology in the area of Cytopathology.

Felix H. Savoie, M.D. recently served as visiting professor at Osaka Kosei - Nenkin Hospital and Osaka University Medical and as special lecturer for the 5th Annual Meeting of the Shoulder Arthroscopy Forum of Osaka, Japan. His lecture was on Advanced Arthroscopic Techniques of the Shoulder.

Mollie Holtzman, M.D., a physical and rehabilitation medicine specialist in Ocean Springs and Biloxi, has successfully completed the certification requirements of the American Board of Physical Medicine and Rehabilitation and is now a diplomat of the board.

Millam S. Cotten, M.D. of Hattiesburg is serving as District Governor 6840 of Rotary International.

Jennifer 0. Hicks, M.D. of Vicksburg has been selected for inclusion in the 1996-97 edition of Who's Who in Executives and Professionals. Dr. Hicks specializes in the practice of obstetrics and gynecology and is employed by VIP Inc., a subsidiary of Columbia Vicksburg Medical Center.

William W, East, M.D. announces his retirement from the practice of Ophthalmology.

Jimmy Miller, M.D. has opened his office for the practice of neurosurgery at Family Medical Clinic of Oxford.

William D. Armstrong, D.O., diagnostic radiologist. announces the opening of Delta Imaging, P.A., serving Greenwood Leflore Hospital and Greenwood outpatient Radiology Clinic. **Patricia Weathersby, M.D.** will also practice as an independent radiologist of Delta Imaging.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

IM/FP Physicians needed to staff clinics in Jackson, McComb, Tupelo and other areas. **Call Russ Offerle, Southern Healthcare•(601) 982-3336 or 800-880-2772.**

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If you have staffing needs anywhere in the State of Mississippi, Temporary or Permanent, call on Southern Healthcare for Physicians, Nurses and medical office personnel. **Call: Joyce Wright, Angela Vinson, or Russ Offerle, (601) 982-3336 or 800-880-2772.**

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Journal MSMA Display Classified ads 1x insertion cost $100.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge.

Items should be sent to: **Placement Service or Classified Section, Journal MSMA, PO Box 5229, Jackson, MS 39296-5229 or Fax to: 601/352-4834**

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Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

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Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

Key Words should follow the abstract and be identified as such. Provide three to five key

words or short phrases that will assist indexers in cross indexing your article. Use terms from the Medical Subject Heading list from Index Medicus when possible.

Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

References must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

Journals

[1] **Author(s).** Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] **Title of article.** Capitalize only the first letter of the first word. [3] **Name of Journal** followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] **Year of publication**; [5] **Volume number:** Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] **Inclusive page numbers.** Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol* 1979;71:680-692.

Books

[1] **Author(s).** Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] **Title**, Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less that four letters. [3] **Edition number,** [4] **Editor's name.** [5] **Place of publication,** [6] **Publisher,** [7] **Year,** [8] **Inclusive page numbers.** Do not omit digits.

Example: DeGole EL, Spann E, Hurst RA Jr, et al. Bedside Examination, in Cardiovascular Medicine, ed 2, Smith JT (ed). New York, McGraw Hill Co, 1986, pp 23-27.

Illustrations should be submitted in duplicate in an envelope (paper clips should not be used on illustrations since the indentation they make may show on reproduction). Legends should be typed, double-spaced on a separate sheet of paper. Photographic material should be high-contrast glossy prints. Patients must be unrecognizable in photographs unless specific written consent has been obtained, in which case a copy of the authorization should accompany the manuscript. All illustrations should be referred to in the body of the text. Omit illustrations which do not increase understanding of text. **Illustrations must be limited to a reasonable number** (four illustrations should be adequate for a manuscript of 4 to 5 typed pages.) The following information should be typed on a label and affixed to the back of each illustration: figure number, title of manuscript, name of senior author, and arrow indicating top.

Tables should be self-explanatory and should supplement, not duplicate, the text. Each should be typed on a separate sheet of paper, be numbered, and have a brief descriptive title.

Acknowledgments are the author's prerogative; however, acknowledgment of technicians and other remunerated personnel for carrying out routine operations or of resident physicians who merely care for patients as part of their hospital duties is discouraged. More acceptable acknowledgements include those of intellectual or professional participation. The recognition of assistance should be stated as simply as possible, without effusiveness or superlatives.

Galley Proofs will be mailed to the principal author for corrections. Reprint order forms will accompany galley proofs. ❑

Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

❧ Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.

❧ Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.

❧ Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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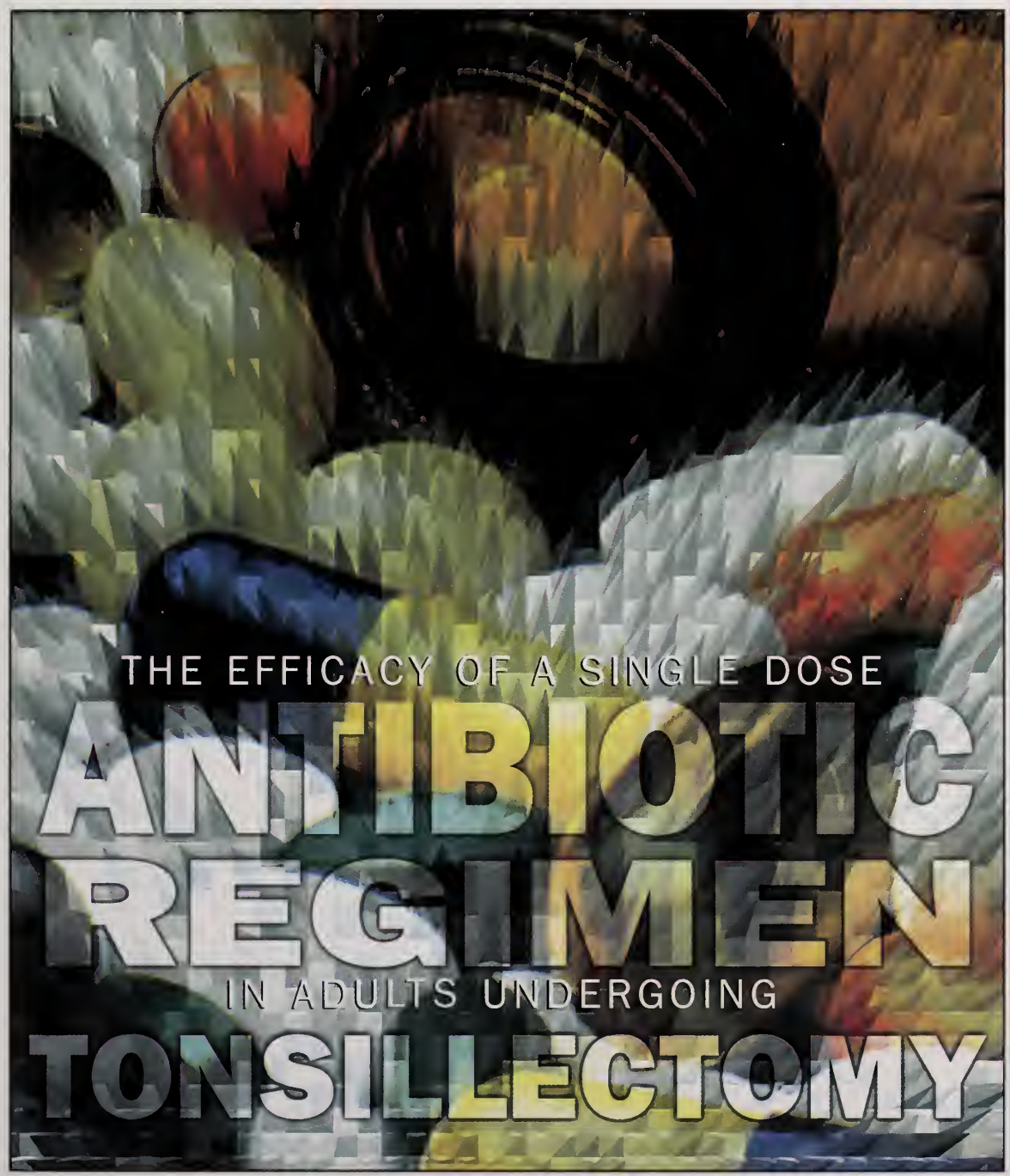
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NOVEMBER 1996



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Breast and Cervical Carcinoma Screening Services: Physicians' Perceptions of Need

Carol E.H. Scott-Conner MD, PhD, MBA
Debra W. Christie MBA, RRA
Ramon McGehee, MD
Beverly L. Anglin, RN, CNOR
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ABSTRACT

The Mississippi Breast and Cervical Cancer Control Coalition conducted a survey of health care professionals to assess current practices in the areas of breast and cervical cancer screening. A 22% response rate was obtained, with family practitioners having the highest response rate. Cost was cited as a major barrier to access to screening mammography. Some discrepancies between provider perceptions and currently accepted guidelines were identified.

KEY WORDS

Breast cancer
Cervical cancer
Papanicolau smear
Surgery
Mammography
Preventive medicine

Breast cancer is the most frequently diagnosed cancer in the US and is second only to lung cancer as a cause of cancer deaths among women[1]. Cervical carcinoma, the third leading gynecologic malignancy, can be prevented by an inexpensive and effective screening method that allows precancerous lesions to be identified and treated[2]. Screening for both breast and cervical cancer is underutilized in the underserved populations[2]. In 1993, the Mississippi State Department of Health received funding for a core capacity building grant to establish a breast and cervical cancer prevention and control program. The Mississippi Breast and Cervical Cancer Control Coalition was formed in March 1994 to: 1) increase state awareness and foster cooperation to combat breast and cervical cancer in the State of Mississippi; and 2) to help develop a plan to secure funding for a comprehensive program to reduce breast and cervical cancer morbidity and mortality through screening, public and profession education, quality assurance, surveillance and evaluation, and to pay for the screening of women unable to afford these services. The Coalition identified a need for information on the current practices of health care providers. Therefore, a survey of health care professionals was distributed in the Spring of 1995.

METHODS AND MATERIALS

The Mississippi State Department of Health compiled a list of physicians practicing internal medicine, pediatrics, obstetrics and gynecology, family prac-

tice, and general surgery. Nurse practitioners were queried as well. A total of 1700 questionnaires were mailed. The questionnaire consisted of 35 items, designed to elicit practitioner beliefs concerning mammographic screening and cervical cytology, barriers to access for Mississippi women, as well as needs for continuing education in these areas.

RESULTS

Of a possible 1700 respondents, 382 surveys (22%) were returned. The largest single group of respondents were family practitioners (29% of those returning questionnaires), followed by obstetrician-gynecologists (20%), internal medicine (14%), and surgical specialties (12%). Nurse practitioners comprised 9%.

Breast cancer screening and control activities

Seventy-five of these health care providers identified cost as the major barrier to access for obtaining screening mammograms, followed by time, access to screening facilities, and geographic availability (in that order). The first screening mammogram was generally recommended by age 40 (**Figure 1a**), every two years between ages 40 and 49 (**Figure 1b**), and annually thereafter (**Figure 1c**) for an indefinite period of time (**Figure 1d**). Women at high risk of breast cancer on the basis of a positive family history were advised to begin screening mammography at age 35 and continue annually. Patient follow-through on screening mammography was estimated at between 76-100% by over half of the respondents. The most common method of evaluation of patient compliance was direct communication.

Only 77% of all practitioners (but 94.7% of obstetrician-gynecologists) routinely perform breast examination on all female patients. Forty nine percent reported attending CME activities related to breast cancer screening. Only 17% reported that they had participated in any active community-based screening programs for breast cancer.

Cervical cancer screening and control activities

Again, cost was identified as the main barrier to care by 44%, followed by time, access, and availability. Over 75% of respondents indicated that annual Papanicolaou (Pap) smears should continue for women over age 40, with a small minority of practitioners advocating "annually until negative", "annually until two consecutive negative", and "annually until two consecutive negative then every three years thereafter". Over half did not feel that a woman could ever be considered to be at low risk for cervical cancer based upon prior negative Pap smears (**Figure 2a**). Recommendations for Pap smear after hysterectomy varied with a substantial minority advocating an annual Pap smear in this group of patients. Patients were notified of the need for repeat Pap smears by a variety of means (**Figure 2b**). Although 88%

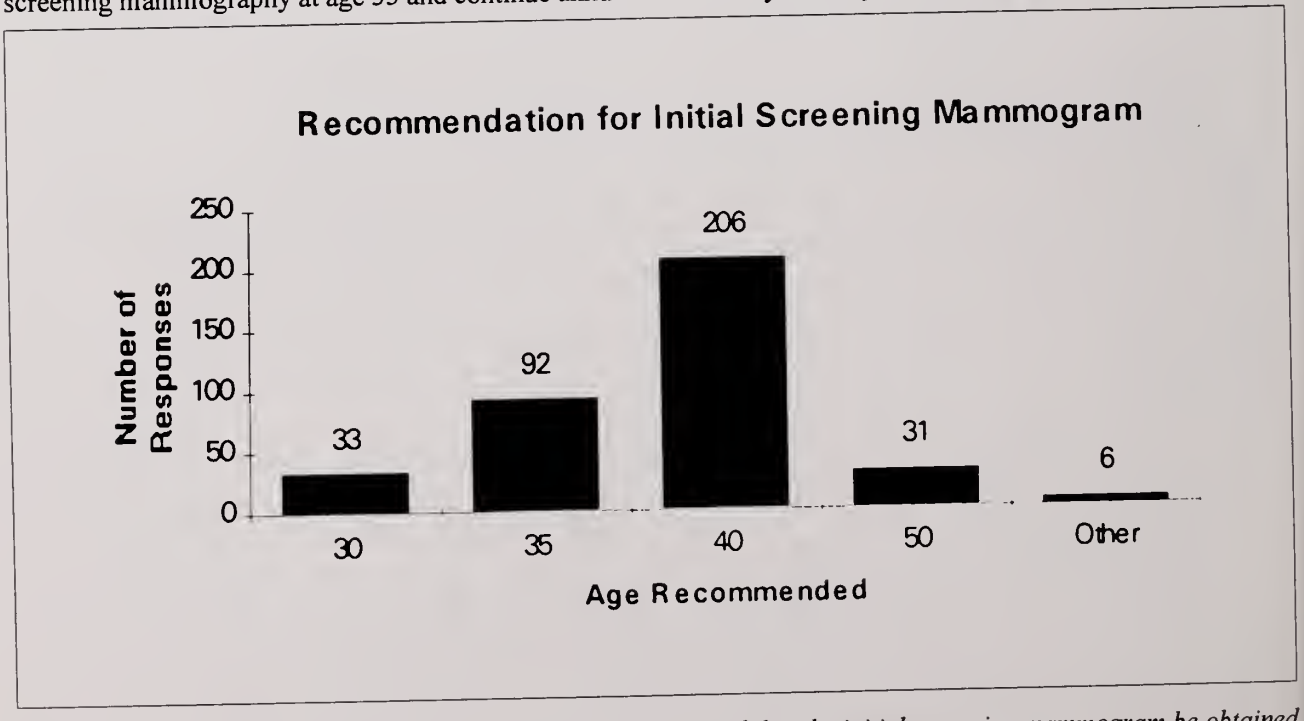


Figure 1a. The majority of Mississippi practitioners recommended that the initial screening mammogram be obtained at age 40.

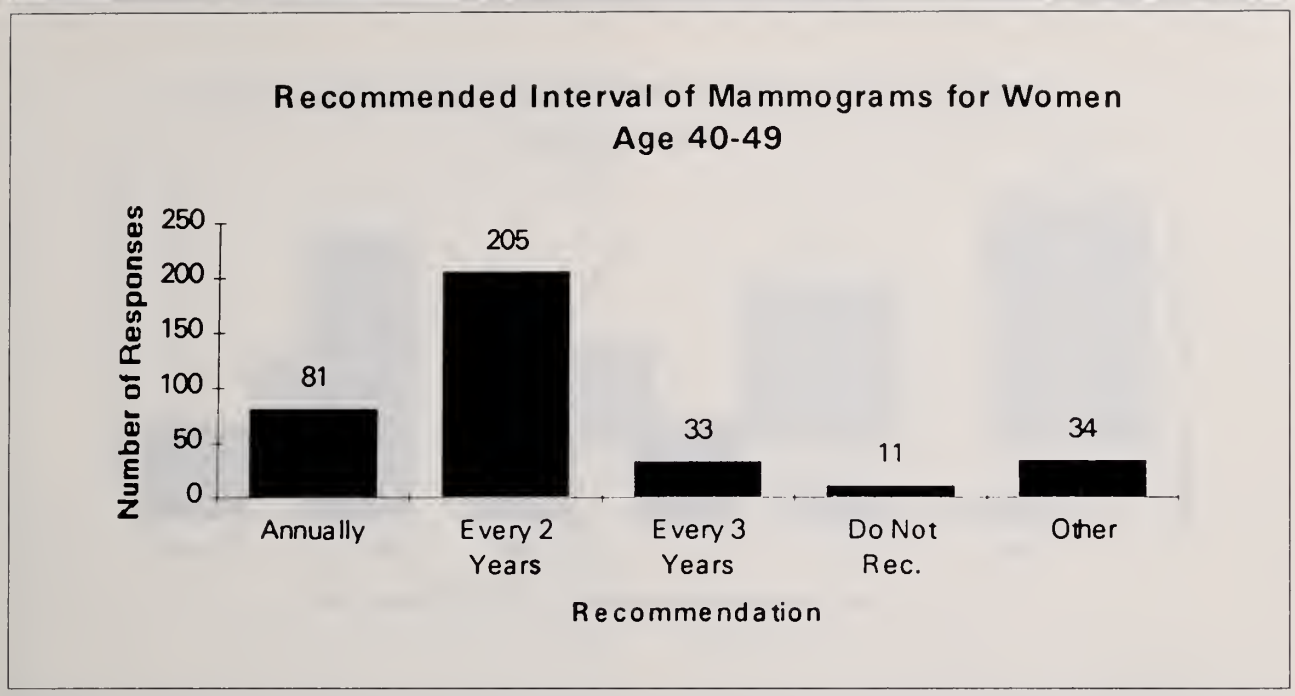


Figure 1b. *Although most physicians recommended that mammography be performed semi-annually between ages 40 and 49, a substantial minority (22%) recommended annual mammography for women in this age range.*

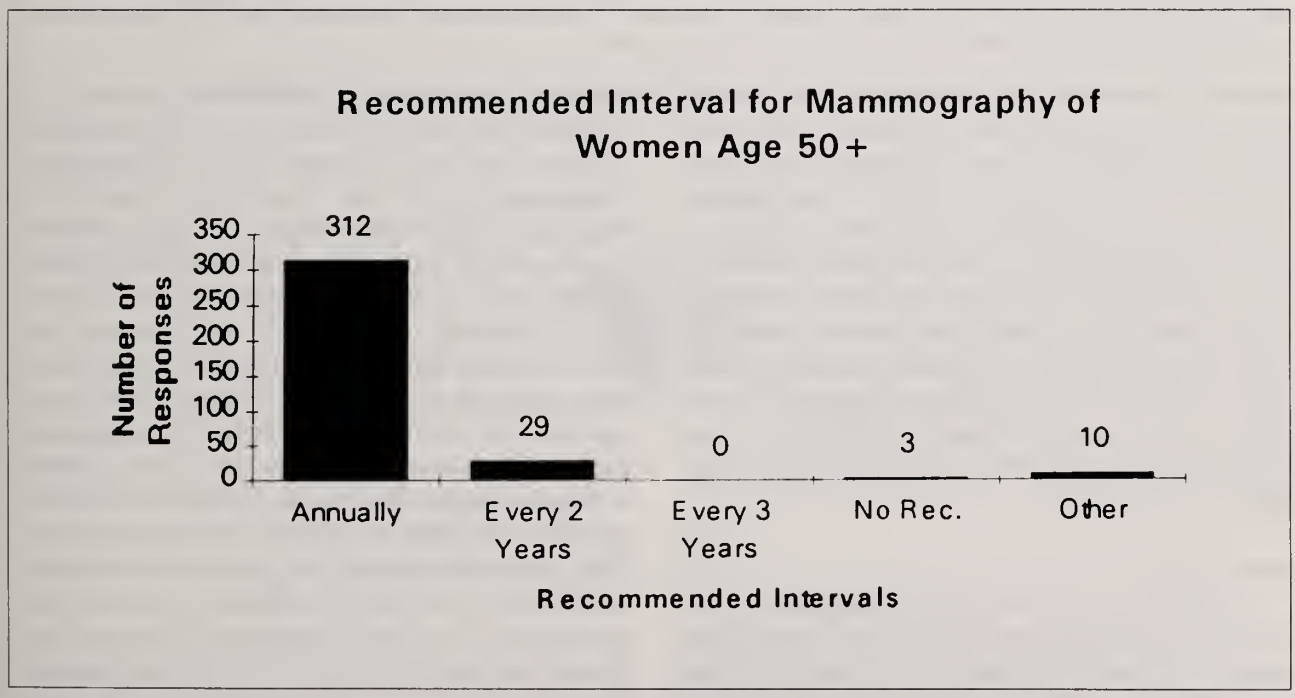


Figure 1c. *The majority of physicians (88%) recommended annual mammograms for women age 50 and older.*

of practitioners indicated that they perform Pap smears, only 12% reported participating in active community-based screening programs for cervical cancer, but 52% had attended CME programs involving cervical cancer.

DISCUSSION

To be of value, screening services must provide demonstrated benefit in survival by diagnosing and treating cancer at an earlier stage[2]. The disadvantages of cancer screening include morbidity and potential mortality due to unnecessary invasive tests to exclude the

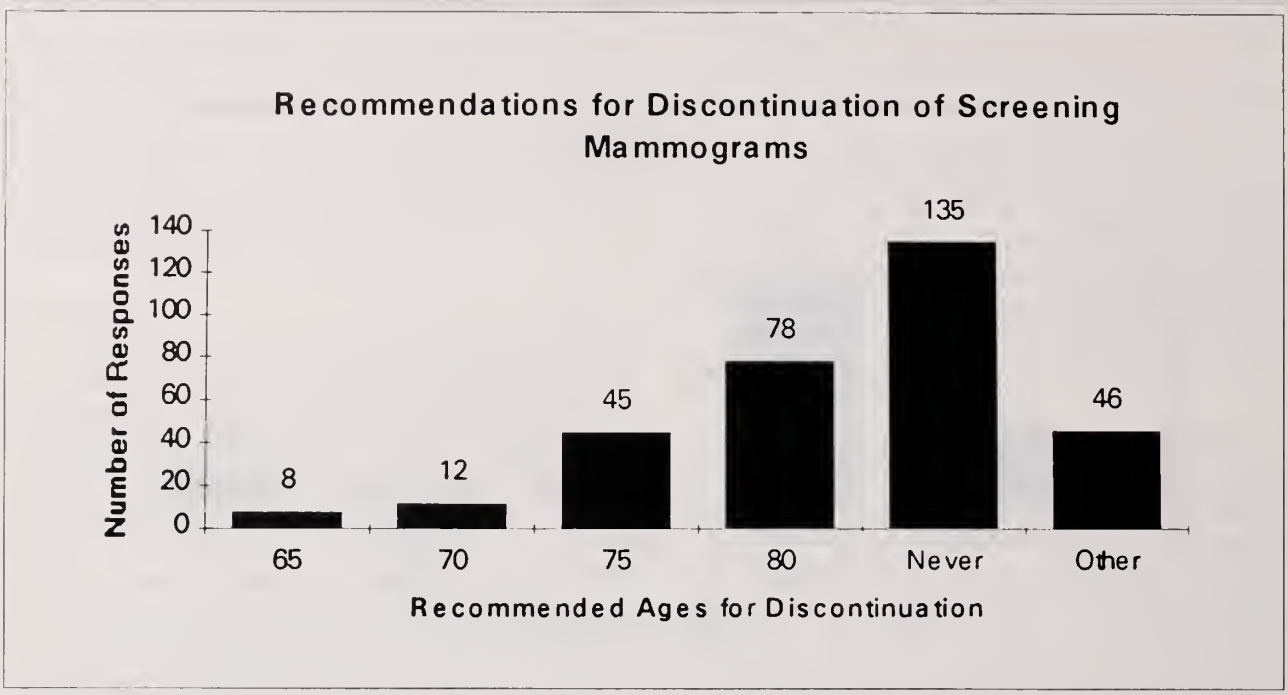


Figure 1d. *Although many (40%) physicians felt that mammograms should never be discontinued, a significant number recommended discontinuing routine mammography for older women; the number of physicians increased with the age cutoff so that 23% recommended not getting mammograms after a woman reached the age cutoff and 23% recommended not getting mammograms after a woman reached the age of 80.*

diagnosis of cancer, the psychological trauma associated with a false positive, the risk associated with a false-negative screening test which may delay needed treatment, and the overall cost to society of implementing widespread screening where benefits are marginal. Ideally, a high-risk subset of the population should be identified in whom screening endeavors are concentrated. The two malignancies under consideration, breast and cervical carcinoma, affect different subsets of the population and are screened by different methods. Hence separate discussion of the results of our survey in the context of currently recommended practice for each malignancy is appropriate.

Breast cancer

Carcinoma of the breast is the second leading cause of cancer deaths in women, and will affect one in nine women if she lives long enough[1]. The incidence rises with age, and although breast cancer does occur in young women, it is women over the age of 50 who are at greatest risk. The American Cancer Society estimates that 1,900 Mississippi women will be newly diagnosed with breast cancer in 1996 and that 460 Mississippi women will die in 1996 from this disease[1]. The two currently accepted means of early detection are clinical breast examination and mammography, which are felt to be complimentary rather than exclusionary. Clinical breast examination is cheap, noninvasive, and should be available to all adult women at the time of periodic medical examination. Mammography may detect breast cancer at an earlier stage than clinical breast exam, but is more expensive, involves exposure to radiation, and may result in unnecessary biopsy. Several studies document the effectiveness of screening women age 50 and over with both clinical breast exam and mammography, showing that aggressive screening decreases mortality from breast cancer in this subset of the population[3-5]. Recognizing this, the US Preventive Services Task Force, charged with evaluating the effectiveness of a multitude of health promotion activities, included clinical breast exam (annually) and mammography (every one to two years beginning at age 50, or at age 35 for those at increased risk) among the recommended screening activities for women between the ages of 40 and 64[3]. Confusion has arisen about the advisability of mammographic screening for women under age 50, and this confusion is reflected in the responses to our questionnaire with a spread of recommended intervals for this age group. Concern about low yield, false positives and negatives, and unproven benefit in the 40-49 year old age group has led to the recommendation that mammography be utilized selectively in these women[3]. Considerable discussion about the risks and

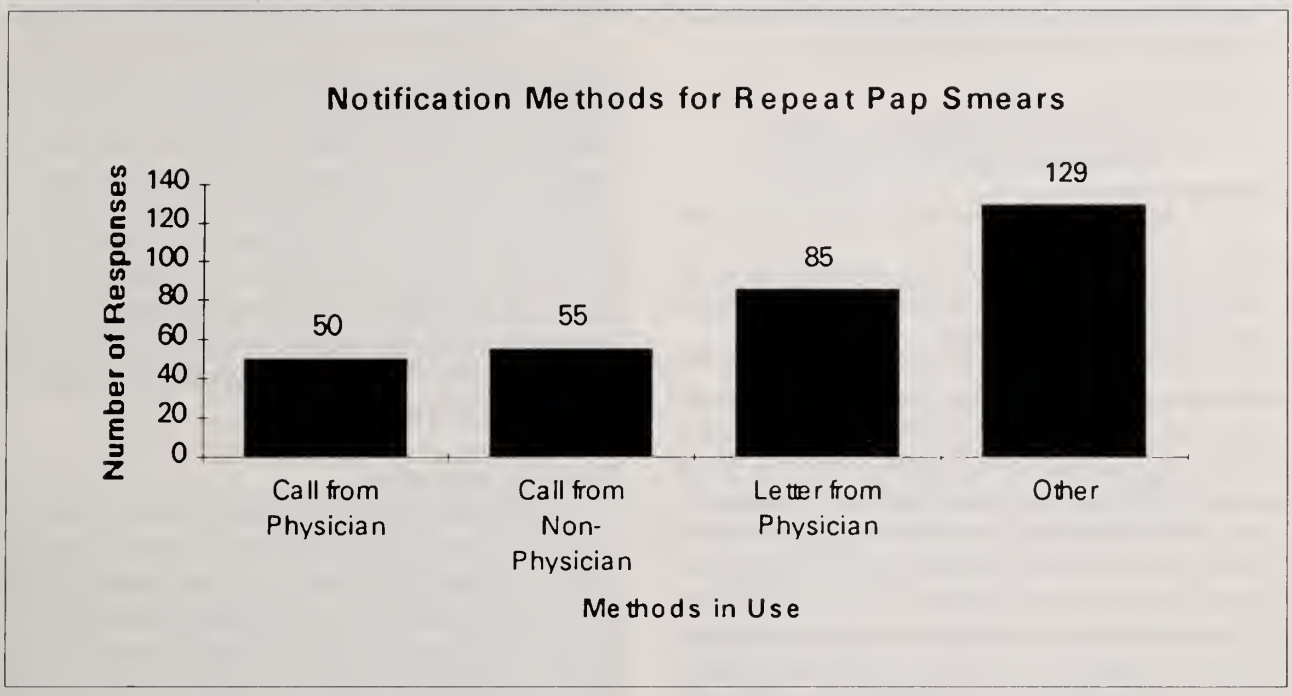


Figure 2a. *A majority of physicians felt that women could never be considered at low risk for cervical cancer, based upon an arbitrary number of PAP smears.*

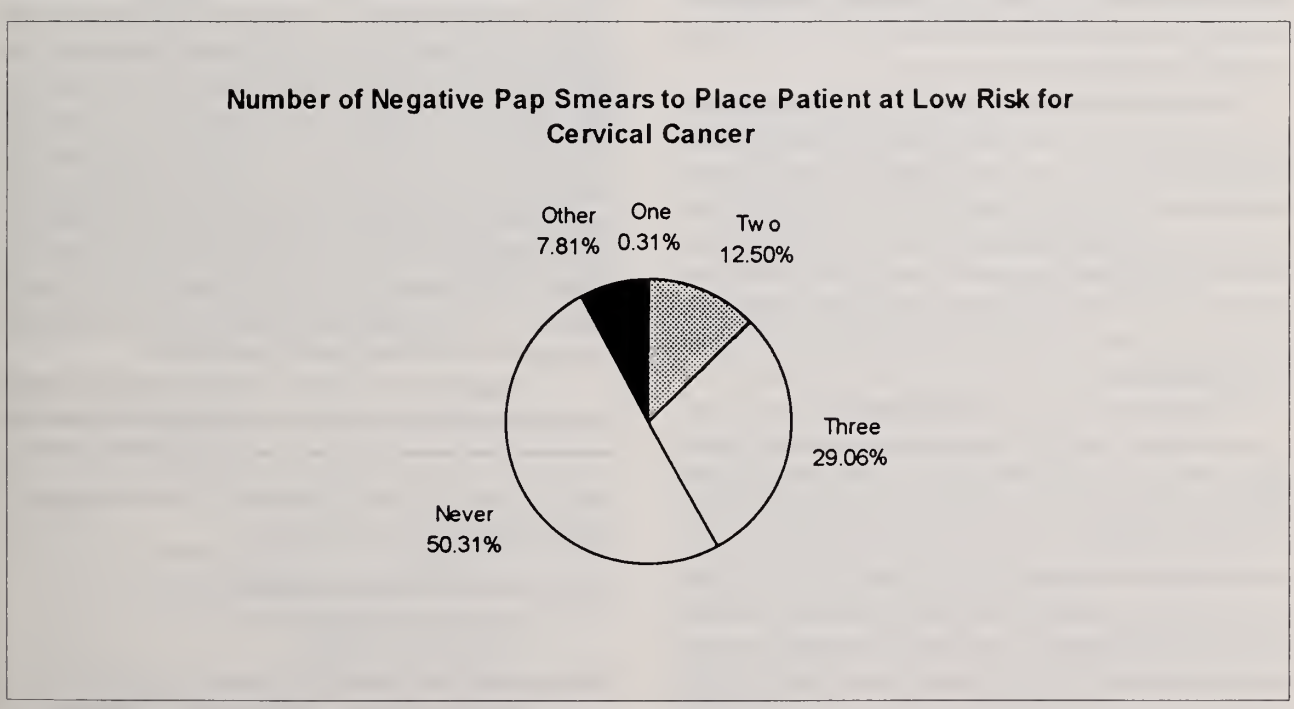


Figure 2b. *Women were notified of the need for a PAP smear by a variety of methods.*

benefits of mammography, with conflicting recommendations from various organizations, has led to confusion among women and physicians[6-9]. The American Cancer Society has produced a set of guidelines which state, in a simple fashion, generally accepted recommendations **(Table I).**

More disturbing than the understandable confusion about advisability of screening younger women, is the uncertainty about whether or not mammography should be continued indefinitely in the elderly. The incidence of

Table I. Summary of Key Points: American Cancer Society Guidelines for Screening Mammography[5]

Begin screening at age 40
- **Clinical breast examination - annually**
- **Mammography every one to two years**

Beginning at age 50
- **Increase frequency of mammography to annually**

These recommendations apply only to the normal woman without signs and symptoms of breast cancer, and may be modified at physician discretion.

breast cancer increases with age and elderly women are at highest risk. The consensus of a forum jointly sponsored by the National Cancer Institute and the National Institute on Aging was that clinical breast examination (every year) and mammography (every two years) should be part of the routine health maintenance activities for all women between ages 65 and 74[10]. After age 75, both clinical breast exam and mammography should continue biennially indefinitely for women whose general health and life expectancy are good[10]. There is some suggestion that breast cancers that occur in the over 75 age group grow more slowly, suggesting that longer screening intervals may be appropriate for women who have not had previously abnormal examinations[11].

It is disappointing that only 77% of all practitioners routinely include breast examination on all female patients, as this activity is a cost-effective means of detecting cancer and provides an opportunity for the physician to recommend mammography if indicated[12-14]. Periodic breast examination is recommended by the US Preventive Services Task Force[3] for women age 40 and above, and is incorporated into the recommendations of virtually all other groups.

Despite general acknowledgment of the advisability of screening, most US women are not screened according to recommended guidelines and we postulate that Mississippi women are no different in this respect[14]. It is of interest that Mississippi physicians identify cost as the major barrier to access to mammography. This is consistent with other studies of physician attitude[12] in which cost, patient reluctance, and radiation exposure were major factors listed by physicians. In fact, cost is a major concern cited by women[15-19]. However, the single most important reason women give for having a mammogram is "my physician recommended it"[12-19], and conversely many women state lack of physician recommendation as a reason not to have the test done[12,21]. Thus the clinician taking primary responsibility for a woman's health has a unique opportunity to transmit important information about advisability of mammographic screening, ideally at the time of clinical breast examination[12-22].

A word about breast self examination (BSE) is in order. There are no studies proving the utility of this method, but many believe that teaching this maneuver to women is an important aspect of health promotion. The American Cancer Society endorses this method as part of a comprehensive spectrum of breast cancer control activities[4]. Several large ongoing prospective trials address the effectiveness of this inexpensive method [2]. The benefits of this activity may be intangible, in that teaching a woman the technique of BSE may help reinforce the message of proactive behavior necessary for effective utilization of preventive services.

Cervical Carcinoma

Carcinoma of the cervix is less common, accounting for an estimated 4600 deaths and 15,000 new cases in 1994[22]. The American Cancer Society estimates that 200 new cases of cervical cancer will be diagnosed in Mississippi in 1996, and that 60 Mississippi women will die from this disease[1]. Identifiable risk factors include early age at first intercourse, multiple sex partners, and smoking[22]. A high frequency of preclinical lesions in young women, and the relatively noninvasive and inexpensive nature of the screening test (pelvic examination and Pap smear) have led most to advocate initiation of screening with first sexual activity or by age 18[22,23]. The US Preventive Services Task Force includes Pap smear (at one to three year intervals) among those screening tests recommended for women between the ages of 19 and 64[3]. Concise recommendations, endorsed by several organizations by consensus, are given in **Table II**[22-24]. In view of these, it is interesting to note that the physicians who responded to our survey varied considerably.

There is general lack of agreement about when Pap smears can be discontinued. Although carcinoma of the cervix tends to occur in younger women than does breast cancer, the peak age of incidence for invasive cervical carcinoma is between 48-55 years[25]. Over 25% of cases are diagnosed in women over the age of 65 and 40-50% of all women who die from cervical cancer are older than 65[22]. Elderly women who have had three

Table II. Summary of Key Points: Use of Papanicolaou Smear to Screen for Cervical Cancer[24]

At age 18 or upon becoming sexually active:
- **Annual pelvic examination**
- **Annual cervical smear**

After three or more consecutive, satisfactory smears:
- **Decrease frequency at discretion of physician**

consecutive negative smears may be considered to be at minimal risk and screening can be discontinued; in Canada, screening is stopped at age 70[2]. Women over the age of 65 who have not had several negative smears should be considered at risk and given continued screening until three sequential negative Pap smears have been documented[2]. In view of the general consensus that it is possible to identify high and low-risk subsets of the population, and that screening frequency can be decreased in appropriate low-risk segments, it is interesting that so many of those who responded to our questionnaire disagreed **(Figure 2a)**.

There are no good guidelines for Pap smear screening after surgical removal of the cervix; however, most authorities feel that the value of the test is limited in this population[2,24]. The American College of Obstetrics and Gynecology states that "the cost-effectiveness of cytologic screening for vaginal neoplasia after removal of the cervix for benign disease has not been demonstrated. In consideration of the low risk of preinvasive vaginal lesions or invasive cancer, however, periodic cytologic evaluation of the vagina, based on the patient's risk factors, is suggested"[23].

What should womens health care providers do? You should include breast and cervical cancer screening or recommend breast and cervical cancer screening to your patients as part of your practice. At a minimum, question your patients about screening practices and promote screening by providing brochures on breast self examination and Pap smears to your patients. Brochures are available free of charge from the American Cancer Society, Mississippi Division and the National Cancer Institute's Cancer Information Service.❑

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The Efficacy of a Single Dose Antibiotic Regimen in Adults Undergoing Tonsillectomy

C. Ron Cannon, M.D., FACS

Abstract

Several studies have indicated that antibiotics given for 5-7 days post-tonsillectomy are beneficial. A prospective double blind randomized study was undertaken to evaluate the efficacy of a long-acting antibiotic (Cefonicid) given prophylactically at the time of tonsillectomy.

Dependent variables were percent weight loss, number of doses of pain medications required postoperatively, the number of days required to resume a normal diet, and return to work. The results of all independent tests indicated that there were no statistically significant differences between the Cefonicid group and the placebo group.

The results of this study indicate that single dose prophylactic application of Cefonicid is not effective in adults undergoing tonsillectomy.

Tonsillectomy in both children and adults continues to be a commonly performed otolaryngologic procedure. This procedure is accompanied by significant morbidity, although fortunately the mortality rates are quite low. A variety of different procedures have been advocated to lessen the morbidity of this procedure. Blunt dissection with tonsillar snare excision has been most commonly utilized in the past, although some authors have advocated electrocautery tonsillectomy.[1] More recently there has been an interest in laser tonsillectomy using various light wavelengths.[2,3] Linden et al in an evaluation of the morbidity in pediatric tonsillectomy found that blunt dissection tonsillectomy using suture ligature hemostasis resulted in the least morbidity.[4]

Telian et al first demonstrated the efficacy of antibiotics post-tonsillectomy in children.[5] In comparison to placebo, they found that Ampicillin greatly reduced the morbidity associated with pediatric tonsillectomy. Grandis et al also demonstrated the efficacy of antibiotics in post-tonsillectomy patients.[6] This study involved adults undergoing tonsillectomy. Both of these studies involved taking antibiotics by mouth for one week postoperatively. Although antibiotics postoperatively have proved beneficial, considerable morbidity in swallowing persists. The compliance of the average patient in taking antibiotics in this situation could be questioned.

The purpose of this study was to evaluate the efficacy of a single dose of antibiotics in adults undergoing tonsillectomy. If successful this method of treatment might obviate the need for antibiotics the week following tonsillectomy when difficulties in swallowing are their greatest. In a previous study by Johnson et al patients

undergoing major head and neck cancer surgery were treated with a third generation cephalosporin for 24 hours postoperatively. Infection rates in these patients were 10% as compared to 78% in a placebo group.[7]

Cefonicid is a cephalosporin with a broad spectrum of activity against most of the organisms implicated in head and neck infections. An advantage to Cefonicid is its unique pharmacokinetics which allows a once daily dosing schedule. Another potential use of a Cephalosporin in this patient population is the increased selective absorption of cephalosporin into inflamed tonsillar tissue as compared to Penicillin.[8]

Materials and Methods:

Patients undergoing tonsillectomy were eligible for the study if (1) there was no history of allergy to Penicillin or Cephalosporin, (2) the patient had not received any antibiotics one week prior to surgery, (3) there were no medical conditions requiring other antibiotic therapy in the postoperative period (i.e. bacterial endocarditis), (4) the patient was more than 12 years of age. (Cefonicid is not approved for those less than 12 years of age.)

The study protocol was approved by the Investigational Review Boards of the involved hospitals. An explanation of the project, its potential dangers, and an informed consult were obtained from all of the participants in the study. Enrollment of patients was continued until 50 patients had been enrolled in the study. The preoperative evaluation included a history to determine the number of episodes of tonsillitis during the preceding year as this was the primary indication for tonsillectomy in most of the patients in the study group. The patient's age, sex, weight, tonsillar size, and evidence of any cryptic debris or evidence of active tonsillar infection was noted.

The patients were prospectively randomized by the hospital pharmacy to receive placebo or 1 gram of Cefonicid which was given intravenously before initiation of the tonsillectomy. Both patients and physicians were blinded as to who received placebo versus antibiotic treatment. None of the patients underwent surgery with acutely infected tonsils.

After the placebo/antibiotic infusion had been infused, the patient underwent tonsillectomy. In all cases, this was performed by a blunt dissection and snare technique. Hemostasis was obtained using the electrocautery at site specific bleeding points within the tonsillar fossa. After meeting discharge criteria, the patients' were discharged home. All patients were discharged home with a journal in which they recorded their daily temperature, diet, amount of oral odor, activities, and number of doses of pain medication.

Patients were seen for follow-up at one week postoperatively and examined, noting their weight, appearance of the tonsillar fossa, trismus, mouth odor, and evidence of any post-tonsillectomy bleeding.

Once the study had been completed the code was broken. The data was analyzed for the Cefonicid and placebo group and submitted for statistical analysis.

Results:

Forty-six patients completed the study and are included in the analysis. Four patients were excluded due to an inadequate data base. The study group consisted of 8 males and 38 females. There were 24 patients in the Cefonicid group consisting of 3 males and 21 females. The age range was 13-40 years of age with a mean of 21.8 years. **(Table 1)** In the placebo group, there were 5 males and 17 females. The age range was 21-33 years with an average of 20.5 years. There were no allergic reactions to Cefonicid or placebo, nor were there any instances of phlebitis. The rates of trismus and any postoperative bleeding were the same for both groups.

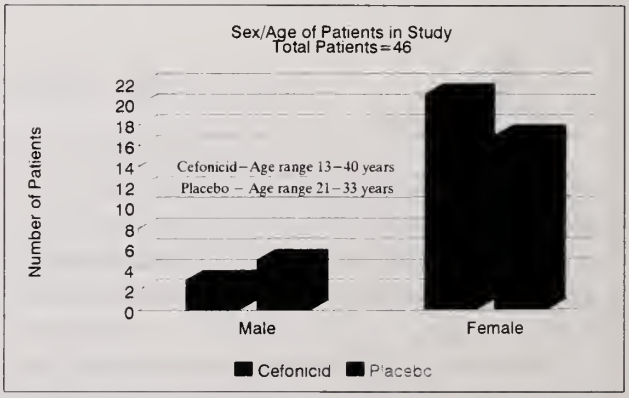


Table 1: Group demographics

The most common indication for surgery in the two groups was recurrent episodes of acute tonsillitis. Twenty-seven of the patients had experienced 4-6 infections during the year prior to tonsillectomy, while 14 patients had experienced more than 6 infections. **(Table II)** On physical exam, the size of the tonsils was assessed. Thirty of the patients had tonsils that were 2+ enlarged (mass of tonsils occupied 25-50% of the oropharynx), while 9 patients had 3+ tonsillar hypertrophy (50-75% of the oropharynx).

When comparing the Cefonicid and placebo groups, the following parameters were studied:

Weight Loss: Most of the patients experienced some weight loss. For the Cefonicid group the average weight

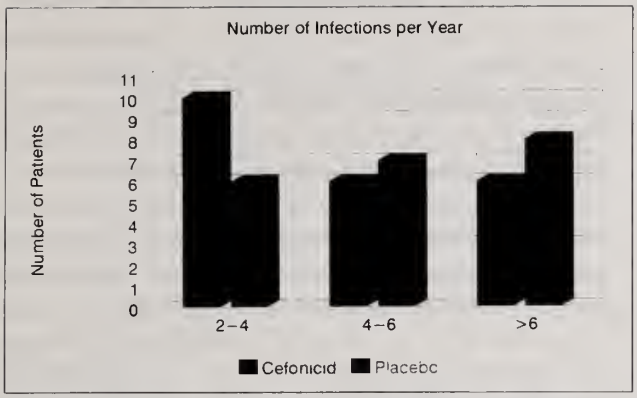


Table II: Number of episodes of tonsillitis prior to surgery

loss of 5.3 pounds. In the placebo group all patients recorded a postoperative weight loss. The average was 8.1 pounds. In both study groups weight loss was greatest on the seventh postoperative day.

Postoperative Eschar: An attempt was made to quantitate the amount of postoperative eschar. (Table III) Clinically, it was felt that an excess of inflammatory eschar in the tonsillar fossa might lead to halitosis, bacterial colonization, pain, and weight loss. A 1+ eschar was defined as scant eschar while a 4+ eschar totally filled the tonsillar fossae. Most of the eschars at one week postoperative were 1+ (Cefonicid 9, placebo 10) or 2+ (Cefonicid 7, placebo 4) indicating no difference in healing between the two groups.

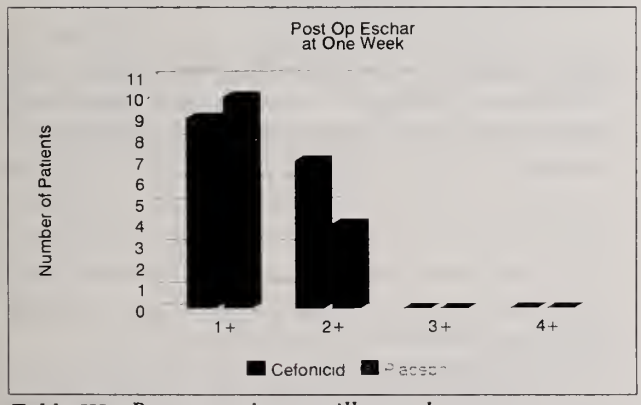


Table III: Postoperative tonsillar eschar

Halitosis was more of a problem for the placebo group as 7 patients noticed a mouth odor at one week postoperative, while only 1 of the patients in the Cefonicid group noted mouth odor at one week post-tonsillectomy. (Table IV)

Fever: All of the patients experienced some low grade, 99-100 degrees Fahrenheit, fever postoperatively. (Table V) In the placebo group this was highest in the first two days after surgery (n=16), while only 6 of the patients in Cefonicid group had their highest fever in the same time period.

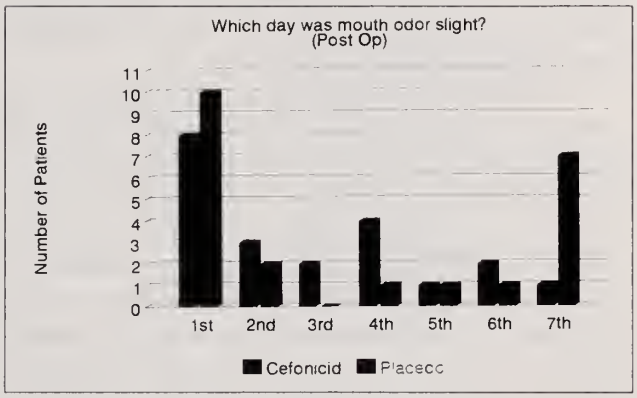
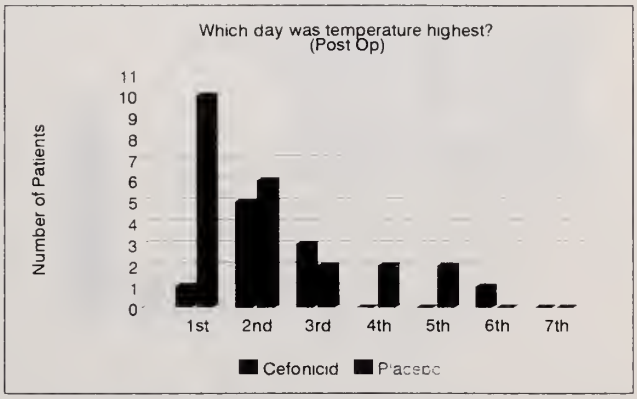
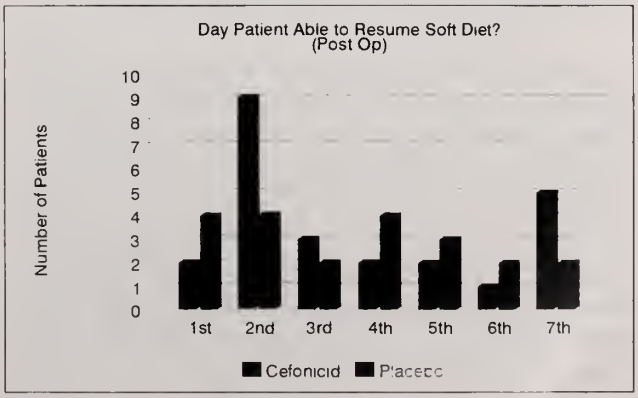


Table IV : Mouth odor following tonsillectomy



TableV: Postoperative fever

Diet: The patients were queried as to which day after surgery were they able to resume a soft diet. (Table VI) In the first three days after surgery 10 patients in the Cefonicid group were able to resume a soft diet as compared to 6 patients in the placebo group. On the second postoperative day, 9 of the Cefonicid group were taking a soft diet as compared to only 4 patients in the placebo group. All of the patients were taking a soft diet at the one week follow-up visit. Overall, however, there were no significant differences between the two groups.



TableVI: Postoperative diet

Analgesics: In the Cefonicid group the number of doses of pain medication (Tylenol with Codeine) varied from 6 to 33 doses with an average of 19.45 doses. In the placebo group the range was 6 to 41 doses with an average of 19.23 doses during the study period.

Activities: The patients were asked to judge their activity level at home.(Table VII) On the fourth day after surgery, 6 patients in each group resumed some activities. On the fifth through seventh postoperative days, 14 patients in the Cefonicid and 16 patients in the placebo group resumed some activities. Return to normal activities was prolonged in each group. At the one week follow-up, 16 of the patients in the Cefonicid group were just resuming normal activities as compared to 18 patients in the placebo group.

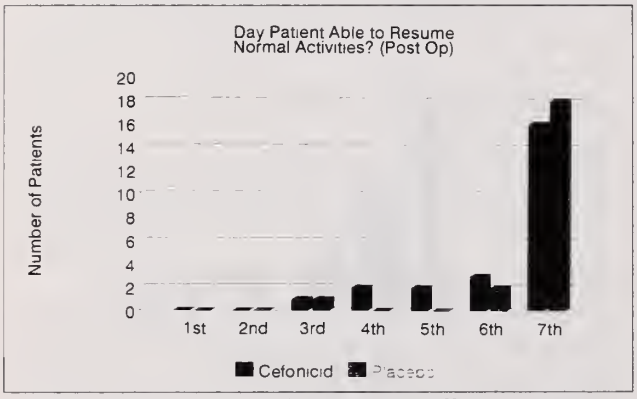


Table VII: Activity level following tonsillectomy

COMMENT

Morbidity following tonsillectomy is a significant obstacle for those patients undergoing this procedure. This is particularly important in the older patient in terms of days missed from school or the work-place. This study was undertaken to ascertain the effects of a single dose of antibiotics on patients undergoing tonsillectomy. In the studies by Telian et al and Grandis et al, the patients were given the antibiotic after the surgery had commenced thus possibly obviating its beneficial effects.[5,6]

The data for each group was subjected to a statistical analysis. An attempt was made to study the Cefonicid and placebo groups in both objective and subjective fashions. Objective parameters chosen were preoperative and postoperative were weight as well as percent weight change. As tonsillectomy is known to be a painful procedure, one of the subjective parameters chosen was that of the number of analgesic doses of pain medicine used postoperatively. Other subjective measures chosen were resuming a diet and normal activities. The t-tests for pre and post surgery weight, as well as % body weight loss were $t(44) = -.41$, $p > .05$, $t(43) = -0.9$, $p > .05$, and $t(43) = -1.67$, $p > .05$ respectively. Thus, objectively there was no difference in the two study groups. Another objective parameter is that of fever following surgery. Gaffney et al have recently shown a 34% incidence of bacteremia associated with tonsillectomy.[9] The lower incidence of fever in the Cefonicid group reflects a lower incidence of bacteremia in this group.

Subjectively, the patients in the Cefonicid group seemed to fare better in the first 24-48 hours after surgery than did their placebo counterparts. The number of doses of pain medications taken by the two groups were remarkably similar. On the second postoperative day, 9 of the patients in the Cefonicid group were able to resume a soft diet as compared to only 4 patients in the placebo group. Thereafter, the differences between the two groups became much less marked. In terms of mouth odor, patients in the Cefonicid group tended to have less odor than the placebo group. Patients in the Cefonicid group showed some increase in normal activities as compared to the placebo group on the fourth and fifth postoperative days. It is felt that Cefonicid protected against bacteria and subsequently this group of patients fared better initially in terms of fever, return to diet, activities, etc. However, bacteria colonization of the tonsillar fossae developed in the two groups and minimized the differences between the two. Statistical analysis of the number of doses of analgesics, days required to resume a soft diet, and return to work (or school) all indicate p values of $>.05$.

The failure of Cefonicid is most likely due to several causes. The soft tissue trauma incurred during tonsillectomy produces a certain amount of pain and eschar formation regardless of the use of antibiotics. Secondly the tonsillar eschar that forms is likely to become colonized with pathogenic bacteria. This phenomenon has previously been studied by Grandi et al.[6] Their study which included post-tonsillectomy fossa cultures showed less growth in those treated with antibiotics as compared to a placebo group.

The role of antibiotics and other treatment measures, such as cautery/laser, injection of steroids into the tonsillar fossa and other local measures continues. The ideal treatment regimen for patients undergoing tonsillectomy remains elusive and has yet to be found. Given its long half life, perhaps the role of Cefonicid might be to reduce bacteremia perioperatively until patients can resume a diet and begin antibiotics by mouth.❑

SUMMARY

A prospective double blind randomized trial of single dose antibiotic (Cefonicid) in adults undergoing tonsillectomy was carried out. Parameters of weight loss, % body weight change, total doses of analgesic, return to a routine diet and work (or school) showed no statistical difference between the Cefonicid and placebo groups. Based on this data, there seems to be no advantage in a single dose antibiotic regimen in adults undergoing tonsillectomy.❑

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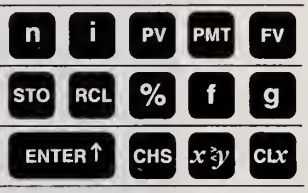
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Fred L. McMillan, M.D.

The President's Page

The Alliance-A Shared Vision

A life in medicine is truly a family commitment and the MSMA Alliance offers our spouses a great opportunity to be part of that commitment. They have such a wide variety of programs, anyone can find a niche that allows them to meet a need - not only their need to contribute but to fulfill a need of others. SAVE-project, Health Choice, Tobacco Awareness, Breast Cancer Awareness, Doctors' Day, AMA-ERF, membership and legislative programs are all a part of the MSMA Alliance projects.

The Legislative Committee has been very active with an effective phone bank and always has members at the Capitol on important days. They have been responsible for many important legislative acts including raising the driving age and family abuse protections laws. They are active in the mini-internship programs with our legislators and the Alliance is extremely active in election years such as this one with the Supreme Court Judge's race.

Health Choice began with 100 participants in 1990 and now it reaches over 6,000 students with "a statewide series of health and drug education seminars for children, parents, and teachers." Jevon Thompson, an international known motivational speaker, puts on a program about sexually transmitted diseases, alcohol, tobacco, drugs, self esteem and self improvement skills.

SAVE (Stop American Violence Everywhere) Program is having a great impact with multiple successful projects. These have included pocket reference guides to assist physician evaluation and documentation of abuse victims. There have been shelter showers held throughout the state. In Hattiesburg, they were able to provide a house that was turned over for a domestic abuse shelter. The Alliance is making progress in breaking the chain of violence that destroys so many Mississippians.

The Alliance is dedicated to improving the health of Mississippians and offering programs throughout the state addressing healthcare needs and concerns such as cosponsoring a Woman's Life Conference in Laurel. There have been Breast Cancer Awareness projects such as pink ribbons, mammogram reminders, posters, and workshops using the SMA's breast model exhibit. I understand that this was a big hit on the University of Southern Mississippi Campus. Newborn mothers are visited and made aware of immunizations that their babies should have and some are given safety car seats.

DOC (Doctors Ought To Care) is a new project on tobacco awareness for fifth graders done in conjunction with the Family Practice Residents at the University Medical Center. Several Alliances have put on very successful Health Fairs with lots of booths. There are multiple other projects including gun, seat belt, and home safety awareness.

The Alliance has multiple appreciation events such as Doctors' Day projects emphasizing physician activities in their community. They have luncheons honoring the widows of physicians and retired physicians have been recognized with parties and the subject of newspaper articles.

Then there is the ever increasingly successful AMA-ERF Project which raises monies for education and research at the University Medical Center. This always takes a lot of time and effort by many every year. The projects include selling wrapping paper, sharing cards, raffle, auctions, and then there was the darn Pink Flamingo in Pascagoula.

The MSMA Alliance has won the AMA Alliance HAP (Health Awareness Project) award four times in a row. This is the first time that a state alliance has accomplished this. Jones County Medical Alliance won it this year for their Women's Life Conference - an education forum devoted to women with Suzanne Summers as the keynote speaker. Previous award winners were South Mississippi - Hattiesburg in '93 with their abuse shelter and again in '95 with a Bone Marrow Drive. Central Medical won the award in '94 for the Blake Clinic Project.

As with any organization membership is a constant priority project. When you pay your MSMA dues this year, be sure to include your spouses alliance dues and if they are not already involved, let them be aware of the opportunities that are available through the Alliance to be part of the family of medicine.

I will close with a quote from Woodrow Wilson which I think denotes one of the reasons the Alliance is so important in the shared vision of the Mississippi family of medicine.

"We shall need [women's] moral sense to preserve what is right and fine and worthy in our system of life, as well as to discover just what it is that ought to be purified and reformed. Without their counseling we shall be only half wise".

Fred

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Editorial

JOURNAL OF THE
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VOLUME XXXVII, NUMBER 11
NOVEMBER 1996

Losses

Death and dying have always held a morbid fascination for me. This is probably true of most physicians, else why would we devote the better part of our lives in what often seems a vain attempt to alter the "expiration dates" of our patients.

But none of us ever completely understands the vast mystery of death. As practicing clinicians we know that attending to the business of the dying patient is just as natural and expected as is the birthing of babies. We are rarely surprised by either process.

We have learned either didactically or through trial and error how to handle ourselves in these situations .... how to inform a patient that he is terminally ill with cancer, how to talk to a mother miles away to tell her that her son was killed in a motor vehicle accident, how best to deal with the families of dying patients.

We study Elisabeth Kübler-Ross' pioneering work **On Death And Dying** and learn that grief is experienced in definite identifiable stages and we recommend the book to others.

We go to all the "Code Blues" when called upon. We work like demons to rescue the perishing. And when we fail, we have practiced and polished our own individual methods of breaking the news to the family who stands outside the door.

Then later at the funeral home we say what we have come to know is the only appropriate thing... "I am so sorry."

Despite our fairly work-a-day experiences with death, when death is handed to us, when it is our own parent, spouse, child, or best friend .... there are no pat answers, no protocol to follow, no text book to look things up in.

At this point the only reference book which offers us as the bereaved any pertinent information is the Bible.

This time it is your loved one who has died. And you are completely unprepared. The situation is totally out of your control. For a physician it seems especially insufferable to feel so powerless ... so helpless ... and out of control.

The past few months have not been kind ones. I lost a lifelong friend in December of 1995. His death hardly seems a reality to me because I could not be there to grieve for him. The knowledge of the permanent state of his absence is quite painful to me.

In March of this year my Daddy died quite unexpectedly in his sleep. A person who goes this way is blessed with the best kind of death... one free of crisis, pain or panic. At almost 80 he still worked daily in construction. On the Saturday before he died he did a plumbing job in the morning and cut up a big old dead pine tree with a chainsaw that afternoon. He ate supper, and watched a video with my two boys, then went to bed and never woke up. My Daddy always knew how to do things right.

As easy as death was for him, I was crushed by the intolerable weight of the idea that he was simply no

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longer there. At the time, it was the worst thing that had ever happened to me, an unabashed "Daddy's girl."

Then, about four months later my husband died very suddenly. And it was not a "good death". There was much crisis, pain and panic.

On the morning of July 5, as was Chard's custom he arose before everyone else, made coffee and started breakfast. Then he walked to the mailbox to retrieve the morning paper. On the way back he experienced a sudden onset of dyspnea. By the time he got into the house he was wheezing audibly and becoming agitated. I remember him saying, "Do something for me, Mama, I can't get any air!"

I mobilized the boys and told them to stay in the house 'till we got back. As acutely ill as he was, Chard made a point of telling them both 'good-bye' before we literally flew the seven miles to town. The acuteness of onset and the apparent gravity of his illness seemed to paralyze me. In the ER he was squeezing my hand and still begging me to do something for him. Never have I felt so helpless or stupid in my life. I remember feeling ...if I can't help my own husband, if I can't save his life, I must be a pretty damn sorry doctor....

At some point one of the R.N.s, in her infinite wisdom, physically escorted me to another room. Bobbie Childs sat me down, held my hands and prayed for us. Looking back, that was one of the sweetest things anyone has ever done for me.

Then we waited. There were times I thought I would literally implode. After an eternity, Dr. David Holloway, a visiting cardiologist from Memphis came out from the "code" room to tell me that things "were not going well."

Having done that very thing and said those same words to families myself on numerous occasions I knew what this really meant ..... "He's dead but we're not ready to tell you yet."

Ratchet me down slowly, boys,

Later, Charlie Elliott a best friend and former partner in practice came out to give me the final word. Bless his heart, we've been through a lot together.

Having read "the book," I breezed right through the 'denial phase', was only briefly demonstrably angry, then I got bogged down in the chapter on guilt.

If only I had ... done this, said that, not done this, not said that.

I should have shown him more love, I should have spent more time with him. Could I have foreseen this? Could I have prevented it?

I quickly became a master of self-flagellation. When death comes, life is examined all too closely.

It has been just over two months and I'm working on Chapter 5 — Acceptance, I have finally (I think) stopped torturing myself with all the imaginary things and the very real things that I'd done wrong over the years.

Having Jesse and Jack helps. Keeping his farm running helps. Staying busy at the clinic helps. It's hard to dwell on your own problems when you face the onslaught of those vastly less fortunate than yourself each day.

I had begun to think I would never dream of him, but the other night I did. He and I were building a log home over in the woods, something we'd dreamed of doing for years. Arguing, laughing, working together... these were the things we did best. It was so normal, so real, not like most dreams. I was truly shocked and saddened when I once again awoke to the reality of my loss.

I was reminded of the words of Canon Henry Scott Holland: "Death is nothing at all. I have only slipped away into the next room. I am I and you are you. Whatever we were to each other, that we are still..."

The hardworking person I knew as my husband has progressed through death to a higher level, another "room" as it were. My job now remains the same as it always was... to make the most of the rest of my life.

All is well.

Dwalia South, M.D.
Associate Editor

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STATE AND LOCAL

Mississippi State Medical Association — Annual Meeting, May 14-18, 1997, Biloxi, Charles L. Mathews, Executive Director, 735 Riverside Drive, PO Box 5229, Jackson 39296-5229.

Mississippi Hospital Association/MS State Medical Association - Health Issues Forum, January 15, 1997, Jackson.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December, James S. Poole, MD, Secy., The Gloster Clinic, PO Box D, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Mrs. Patsy Douglas, Executive Secy., 735 Riverside Dr., Jackson 39202. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale, Glen L. Wegener, MD, Secy., PO Box 430, Clarksdale, MS 38614-0430. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, March, June, and November. James E. Clarkson, MD, Secy., Mail: Ms. Leslie Johnson, PO Box 128, Biloxi 39533. Counties: Hancock, Harrison.

Delta Medical Society, 2nd Wednesday, April and October. A. Randle White, MD, Secy., 609 Tallahatchie St., Greenwood, MS 38930. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, MD, Secy., Mail: PO Box 5025, Meridian 39302. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society. Meetings scheduled quarterly, J. Chris Hancock, MD, Secy., 46 Sergeant Prentiss Dr., Suite 9, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January, Robert H. Curry, MD, 500 A Hwy 9 S, Eupora, MS 39744. Counties: Attala, Carroll, Choctaw, Granada, Holmes, Montogomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. B. Shane Tucker, MD, Secy., Mail: Ms. Brenda Mabry, PO Box 2180, Tupelo 38803-2180. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, and 3rd Thursday, January. Catherine E. Gleason, MD, Secy., 1308 Belk Blvd., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Prairie Medical Society, 2nd Tuesday, March, June, September, December, William R. Locke, MD, Secy., 107 Doctors Park, Starkville, MS 39759. Counties: Clay, Oktibbeha, Noxubee, Lowndes.

Singing River Medical Society, Quarterly, December, March, June and September. Roland Mestayer, MD, Secy., Mail: Mrs. Lujean Trumble, P. O. Box 231, Pascagoula 39568-023. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Jr., MD, Secy., PO Box 1910, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. William A. Whitehead, MD, 415 South 28th Ave., Hattiesburg 39401-7246. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, May, September, November, 6:30 p.m. Maxwell's Restaurant, Vicksburg. Daniel Edney, MD, Secy., 1901 Mission 66, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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Biloxi, MS 39530

Charter Behavioral Health System
3531 East Lakeland Drive
Jackson, MS 39296

Council on Scientific Assembly
MS State Medical Association
735 Riverside Drive
Jackson, MS 39296

Delta Regional Medical Center
1400 East Union Street
Greenville, MS 38704

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

Greenwood Leflore Hospital
1401 River Road
Greenwood, MS 38930

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Gulf Coast Medical Center
180 DeBuys Road
Biloxi, MS 39531

Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

King's Daughters Hospital
Highway 51 North
Brookhaven, MS 39601

King's Daughters Hospital
300 South Washington Street
Greenville, MS 38702

Memorial Hospital at Gulfport
4500 13th Street
Gulfport, MS 39502

Methodist Hospital of Hattiesburg
5001 Hardy Street
Hattiesburg, MS 39404

Methodist Medical Center
1850 Chadwick Drive
Jackson, MS 39204

MS Baptist Medical Center
1225 North State Street
Jackson, MS 39202

MS State Department of Health/
MS Association of Public Health Physicians
Post Office Box 1700
Jackson, MS 39215

Natchez Regional Medical Center
54 Sergeant S. Prentiss Drive
Natchez, MS 39121

North MS Medical Center
830 South Gloster Street
Tupelo, MS 38801

Northwest MS Regional Medical Center
1970 Hospital Drive
Clarksdale, MS 38614

Rush Foundation Hospital
1314 19th Avenue
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PHYSICIANS NOT THE BAD GUYS IN HEALTH-CARE PICTURE-THE RECORD OF MEDICAL SCIENCE IS GOOD AND NEEDS TO BE TOLD

When we physicians hear, view, or read poorly researched negative reports about medical costs or inflation, we immediately respond defensively. We feel guilty, hurt and reluctant to discuss it.

I would suggest instead that we take an in-depth look at this issue and study the value-cost ratio of medical care today as compared with the reference point of 1970, when medical costs were 7 percent of the GNP instead of today's 14 percent.

I suspect every physician can look at the quality of care delivered in his or her specialty today and quickly decide that the value of care delivered has grown far more than the cost. Somehow, however, our critics would imply that the quality of healthcare hasn't changed, but the cost has become exorbitant.

I refuse to accept that assertion. For example, since 1970, deaths from heart attacks have dropped 40 percent. I am sure similar advances have occurred in all the specialties. We are clearly able to do much more for our patients today than at any time in the history of medicine.

I doubt any of us wish to return to the 1970 quality of care, and I don't know of anyone in the United States who has sought health care in other countries with reportedly lower health care costs. It is time for us to praise health care in the United States rather than to apologize for it.

Let me review some reasons health care costs have risen:

•Aging of our population: Since 1970, life expectancy in the United States has risen by an incredible six years. This has happened despite, as syndicated newspaper columnist Mike Royko wrote, "A nation of self-indulgent, large-butted TV gaping couch potatoes." The fastest growing segment of our population is the over 75 age group: The annual cost of providing health care to those younger than 25 is $900 compared with $9,000 per year for those who are 75 or older. We don't need to or choose to apologize for increase in life expectancy.

•Technologic advances and pharmacologic advances: I am confident that 90 percent of the drugs I have prescribed and the technology that I apply today were not available when I completed my residency in 1965. Coronary angioplasty and other interventions have proven highly effective in improving quality of life as well as quantity of life. Thrombolytic drugs save hundreds of thousands of lives yearly in heart attack victims. Research is expensive, but none of us wish to see research and medical advances stifled by economic restraints.

•Defensive medicine: The cost of liability insurance has quadrupled in only the past 15 years. Despite trial lawyers assertions to the contrary, the practice of defensive medicine is very real, and it is expensive. The best independent studies today report annual cost of defensive medicine to be $25 billion to $35 billion. Effective tort reform could go a long way toward significantly reducing health care costs.

•Unhealthy life styles: This may represent the area with the most potential for cost saving. The medically related annual cost of tobacco use, drug and alcohol abuse, teenage pregnancy, family violence, and the lack of regular exercise is currently $265 billion. Consider that carefully. A full 26 percent of healthcare dollars spent in 1994 could have been avoided or remarkably reduced by healthy life-style habits. Compared with other developed countries, we rank near the bottom of the healthy life-style scale. The public does have a responsibility to contribute to this rush to contain health care costs.

•Consumer demands: In the United States we have come to expect the very best educated physicians in the world, access to the very latest technology, and we want it to be in a very timely manner like today or tomorrow. In Toronto, Canada, on the other hand, an average of 100 patients are waiting for coronary bypass surgery on any given day. Their wait averages six to eight months and the mortality of waiting is actually higher than the operative mortality. We neither want nor deserve that quality of "free health universal coverage" in the United states. Someone has correctly stated, "If you think health care is expensive now, just wait until it is free."

Despite thes obvious reasons for health care cost escalation, we providers also have a role to play, in cost containment. We must assume our appropriate responsibilities where possible." We clearly have too many hospital beds, too few primary care physicians, and too many specialists.

•Our medical school and residency programs need to focus more attention on preventive health care, preventive healthcare education, and appropriate selection and use of expensive high technology. I believe we also have a major obligation to communicate better with our patients and families at the end of life. Thirty percent of health care dollars are spent in the final year of life. Most of that is appropriate, of course, but as difficult as it is, we

need to reduce non-beneficial care in futile situations, and instead focus more on comfort and compassion care. This should not be done to save money, but because it is the right thing to do.

Economists and regulators try to place the responsibility for the rise in health care cost at the feet of physicians. Consider this, however, physicians receive 19 percent of the health care dollar.

That means that with more than 50 percent practice overhead, if a physician's reimbursement were cut by a full 50 percent, the actual reduction in healthcare cost would be only 4.5 percent.

I hope for the day when policy-makers allow physicians to participate in the process of health reform so effective cost containment can be done without giving up quality care to our patients.

If we can help our critics and the public focus on the value of the excellent medical results they are getting as much as the dollar spent, I believe they will agree, that the value-cost ratio has grown dramatically. We physicians need to take an offensive rather than defensive posture in this debate.❑

-Chester W. Masterson, M.D.

*Dr. Masterson is a guest columnist for the **The Vicksburg Post** from which this was reprinted. He is a Fellow of the American College of Surgeons and has practiced in Vicksburg about 30 years. Dr. Masterson is with the Eye, Ear Nose & Throat Clinic on Mission 66.*

RURAL CLINICS BECOME BONANZA

A Greenwood doctor, an acquaintance of mine, telephoned me the other day. He was upset about a report he had just seen. The report was titled, "Provider Based Rural Health Clinics: Medicaid Reimbursement for the Usual Office Visit."

The report showed significant billing discrepancies among Mississippi's rural clinics for a usual office visit.

For instance, the Greenwood Leflore Hospital charges $45 for a usual office visit Many other hospitals and clinics $25 to $40.

However some clinics are charging over $200 for a usual office visit- nearly five times as much.

The Greenwood doctor wanted to know how a usual office visit can cost $25 at one clinic and then cost $230 at another clinic just a few miles away.

"If they go to my office I get about $10, but if they go to one of these clinics, they see a nurse practitioner and the clinic gets $200," my friend the doctor complained.

The source is federal regulations designed to encourage new clinics in rural areas. The new clinics are allowed to charge whatever they want, creating a gold mine for eligible rural health providers.

As a result, rural health clinics have increased 143 percent in two years and some entrepreneurs are getting rich.

Helen Wetherbee, the director of Mississippi's Division of Medicaid, doesn't like the new federal regulations one bit.

"The idea was to attract health care manpower to under-served areas," Wetherbee said. So instead of fee-based reimbursement, these guys were reimbursed at 100 percent of their costs. We're paying hundreds of dollars per patient visit because we're paying for the entire cost of building the clinic."

Wetherbee said she is not aware of any upper limits to how much a clinic can be reimbursed. Whatever their costs are, that's the amount they get back from the government.

"I think the original idea was well intended, but the lack of scrutiny and the lack of reasonable limits has been irresponsible," Wetherbee said. "The door is wide open for abuse."

Not everybody can get into this business, which is one reason many doctors are complaining.

The new cost reimbursement bonanza is only available for existing hospitals, nursing homes and home health care providers - all of which are limited by Mississippi's "certificate of need law."

Clara Reed, a Belzoni nurse, runs a veritable empire of health clinics.

Because Reed's company started out as a home health care provider, she was able to start health clinics using government money.

Her company, Mid-Delta Home Health, now has seven clinics throughout the Mississippi Delta. She employs more than 700 in the clinics and her home health agency, making her the biggest company in Belzoni.

Mid-Delta has some of the highest charges of all the health clinics, typically charging five times the normal rate for a "usual office visit."

Her clinics are the Cadillacs of health care, providing a panoply of services unimaginable just a few years ago.

Her clinics all have psychiatrists, psychologists, psychiatric nurses and social workers." These people are

(continued on page 834)

on staff and have to be paid," Reed said.

Her clinics offer preventive health care, disease screening, physical therapy, speech therapy and other advanced services.

"You don't find those services in other physicians' offices," she said. "If you start from scratch, your costs are going to be high. We project the number of visits we expect and then divide it all into our overhead."

Reed sees her clinics as one of the few places that troubled young black males can receive help.

"These kids are identified in school as having problems, but they are never treated," she said.

I asked Reed why her clinics charge four times more for an office visit than the Greenwood Leflore Hospital.

"If you look at how long that hospital has been in business and the number of patients they have, they can afford to offer services at a lower cost," she said.

Wetherbee, Mississippi's Medicaid director, said many doctors are discouraged because they don't qualify for the cost-based reimbursement bonanza.

"One physician gets $30 and another gets $200. This is infuriating to those health care providers who we need the most," Wetherbee said. "If these providers are discouraged by the inequity of the system, then they may leave the state and then Medicaid will really be hurt."

Reed said she has to pay doctors more to get them to come to rural areas. Once her start-up costs are paid for, she predicted her clinics' costs would come down.

Mississippi has a moratorium for new nursing homes and home care providers. As a result, only certain existing health care providers can take advantage of full-cost reimbursement.❑

-Wyatt Emmerich

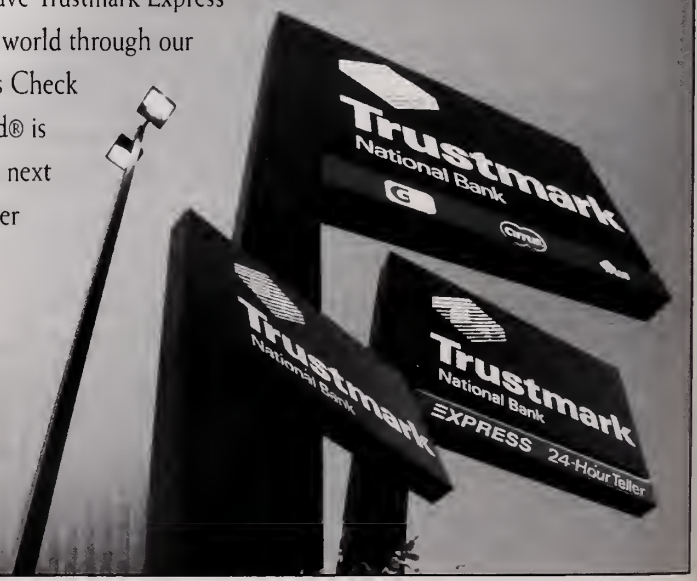
Wyatt Emmerich is president of Emmerich Newspapers and publisher of the ***Northside Sun*** *from which this was reprinted.*

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Physician Biographical Information Now up on the AMA Web Site- http://www.ama-assn.org

All 650,000 U.S. Physician Biographies up on the Internet

For every year he has been in practice, gastroenterologist Richard Corlin MD., has paid up to $8,400 annually for a simple listing in the Yellow Pages with his name, address and phone number. Today, Dr. Corlin has his entire medical biography up on the AMA's Internet Web site, at no cost.

AMA's new pro AMA Health Insight contain both the new patients' medical "Reference Library" and a new physician information database called "AMA Physician Select."

The AMA database, the most comprehensive listing of all U.S. physicians, lists a physician's education, residencies, board certification and other significant biographical information available. Patients can search the database by physician name, location or specialty.

"Patients can now pop-up on the Internet or head to the public library and find a biography on their physician in a matter of seconds," said Richard Corlin, MD., Speaker of the AMA House of Delegates. "You also can search your town by specialty and find a list of all the licensed physicians in the area. This is a great tool for members of the public seeking the best physicians for themselves and their families."

AMA Physician Select

Although many local medical societies offer similar on-line search services listing member physicians, AMA Physician Select is the first nationwide database of all licensed physicians available to the public. Searches can be conducted by 23 major specialties and 150 subspecialties, and by city, zip code, state or by name. AMA Physician Select provides the physician's name, address, phone number, gender, medical school, all residency and internship information, specialty board certification and AMA membership.

AMA Patient Reference Library

The AMA Patient Reference Library contains information about the AMA and the medical profession and a link to information and resources on diseases, such as the JAMA/HIV AIDS Information Center. The HIV Center features clinical updates, daily news and information on social and policy questions related to AIDS, under the direction of JAMA staff and an editorial board of leading HIV/AIDS authorities.

AMA Members Receive Expanded Site

All AMA members are offered an "expanded web page site" to list additional practice information, including practice philosophy, health plans accepted, hospital privileges, group practice affiliations, personal information practice hours, and even a photo. All AMA members are also identified in the database by the AMA logo, as are recipients of the AMA.

Physician's Recognition Award for Continuing Medical Education.

"We expect 30 to 50 percent of patients to use the Internet at home or in local libraries to find out more about their physicians," said Corlin. "The expanded web pages are much more than a yellow page ad. It's like a brochure placed in the hands of thousands of potential patients."

Only AMA members are eligible for the "expanded web page" listing, although AMA's Corlin jokes that any potential AMA member can purchase an expanded web page for $425 — the price of AMA membership. "They can get the expanded web page and all the other benefits of membership for $425 annually, less than the monthly cost of that Yellow Page ad."

The AMA launched its award-winning site on the

Internet in August of 1995 and includes clinical abstracts and articles from the Journal of the American Medical Association and AMA's nine specialty journals. All press releases, statistics and award-winning American Medical News summaries are on the AMA's web page, along with a data base of 7,000 approved medical residency programs for graduating medical students. In addition, all state, county and specialty medical societies with existing home pages are accessible through the AMA's web page. More than 2.5 million visits to the AMA web site were logged in the last year. AMA has maintained a listing of all physicians licensed and educated in the United States since 1906. The AMA has opened that database to the public "to help patients weigh their options and find the best physicians for their needs," according to Corlin.

"AMA Physician Select is revolutionary. Never have patients been able to gather so much information on their physician at the click of a computer mouse," said Corlin. "Our Patient Reference Library promises to do the same for all of those looking for the most up-to-date, reliable information on a broad spectrum of conditions." Patients can search over 150 specialty categories and click to obtain definitions. Soon, consumers will be able to find a doctor by using AMA Physician Select to search by illness, symptom and more.

The AMA database includes only actively licensed physicians. Neither will liability awards against physicians be made available, according to Corlin. "It's impossible to interpret such information," he said. "Unfortunately it can be the most skilled physicians with the sickest patients who find themselves in court and the average obstetrician is sued twice every 10 years, regardless of professional competence."

AMA's Internet Web Site address is http://www.ama-assn.org.❑

You are invited to attend

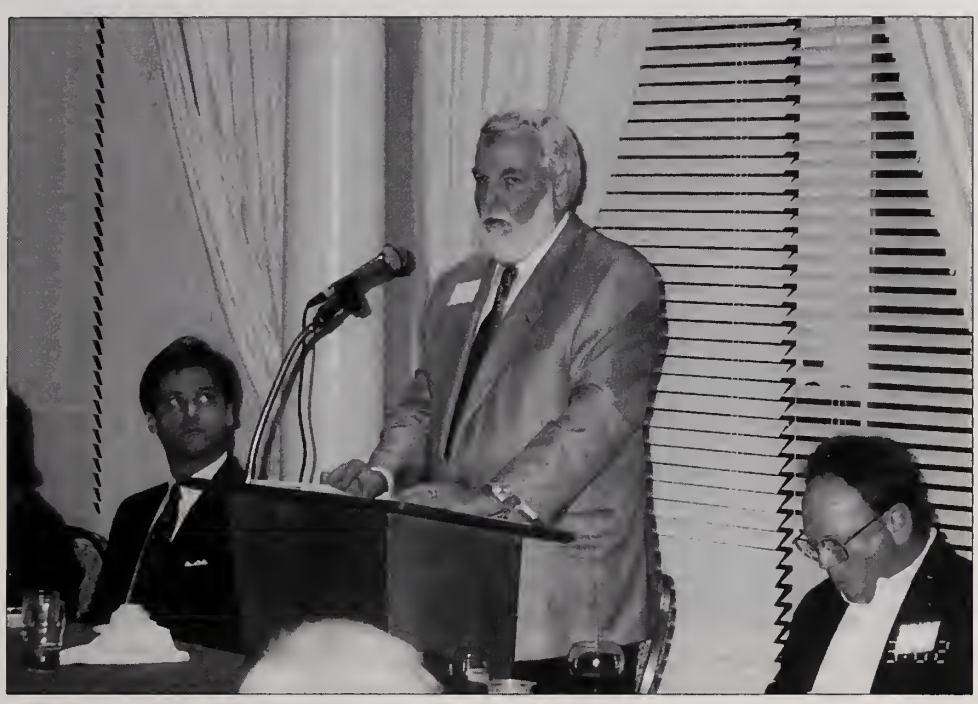
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MSMA President Dr. Fred McMillan *addressed the Northeast Mississippi Medical Society in Tupelo. Seated left is* ***Dr. Mark Kellum, Northeast Mississippi Medical Society president-elect****. Seated right is* ***Dr. Thomas Oakes, Northeast Mississippi Medical Society president.***



MSMA President Dr. Fred McMillan; Dr. Thomas Oakes, Northeast Mississippi Medical Society president; Mrs. Thomas Oakes *and* ***Dr. Lee Rogers.***



The Northeast Mississippi Medical Society met in Tupelo. Shown left to right, ***Dr. Thomas Billups*** *of Tupelo,* ***Dr. and Mrs. John Patterson*** *of Pontotoc.*



Shown left to right, ***MSMA Assistant Executive Director and Legal Counsel Bill Roberts, Dr. Richard Heyer and Dr. William Marcy,*** *both of Tupelo.*

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AIR FORCE

Flu Campaign '96 Underway in State

James S. McIlwain, M. D.
Principal Clinical Coordinator

The strategies to increase the number of influenza immunizations are unfolding this fall throughout the state. The "flu season" is not welcome, but it is expected, and it is hoped that plans to have many more flu shots administered this year will be successful.

Numerous articles in a variety of publications have discussed, proclaimed and emphasized the importance of the flu shots. The focus for the Foundation's general campaign and the Horizons campaign with Jackson State University's Urban Research Center are the Medicare-age beneficiaries who can claim free shots if they have Part B and get the shot from someone who takes assignment.

This is the third year for the program, which is enhanced through the efforts of numerous organizations, including the State Department of Health, the state's Part B carrier MetraHealth, Blue Cross & Blue Shield, Part A, the End Stage Renal Disease Network Region 8, the Lung Association, the Council on Aging, and the AARP.

The 1993 statistic in Mississippi reflected a 24 percent rate of immunization, lower than the national rate of 35 percent. Mississippi's influenza immunization rate for 1995 was 29 percent. The Health Care Financing Administration's Healthy People 2000 goal is 60 percent. Reaching these numbers represents a challenge, and the flu project has been developed in the state to attain this goal.

The Foundation is working in its general flu project with providers in five target counties, Washington, Sunflower, LeFlore, Grenada and Jones, because of low immunization rates. The Foundation is encouraging each hospital in these counties to institute standing orders for the influenza vaccine. Research has shown that hospitals with standing orders tend to assess and ultimately vaccinate more patients than hospitals without standing orders.

To help facilitate this process, the Foundation suggests use of assessment stickers on the front of charts, with stickers to be provided by FMC. Also, distribution of flu information on admission will include a fact sheet also provided by FMC. Flu posters for display throughout the facilities will be provided to encourage participation.

Sponsorship of a "Flu Shot Day" in an outpatient setting has also been suggested. Flyers, media coverage, and direct mailings to Part B beneficiaries will be included along with appropriate billing facts.

Hospitals are requested to stress participation to provider-based rural health clinics. A contest to reward the rural health clinic staff immunizing the highest percent of Part B beneficiaries is planned.

The JSU Urban Research Center Flu Plan

Counties in the Horizons pilot program for 1996 which will receive intense efforts stressing the importance of the flu shot for African-American Medicare recipients include Hinds, Rankin, Madison, Quitman, Panola and Coahoma. Direct mailings which will include a brochure featuring Dr. Aaron Shirley, director of the Jackson-Hinds Comprehensive Health Center, stressing the importance of the flu shot will be mailed to beneficiaries in these counties. Proclamations declaring October as "Horizons Month" were signed in the city of Jackson. Churches are participating in the program to transport beneficiaries to flu shot locations. Health fairs, the State Fair, including Senior Day, and other special events are being utilized to emphasize the importance of the flu shot. The campaign will include measuring the impact of the pilot program. Analysis of effective interventions will lead to a statewide Horizons project in 1997.

"We feel this is a beneficial endeavor; through the cooperation of the Foundation, Jackson State University and vital Mississippi hospitals, the Healthy People 2000 goal of increasing the immunization rate of Medicare beneficiaries should be reached," said Dr. Alton B. Cobb, clinical coordinator.❑

UMC Begins Transformation Process on Former Jackson Mall

The process of transforming the nearly-vacant Jackson Mall in central Jackson into a multipurpose health care facility-the Jackson Medical Mall-has begun nearly one year after the idea of an integrated health care facility was conceived.

The nonprofit Jackson Medical Mall Foundation, of which UMC is a founding member, conducted the ceremonial shoveling of dirt before an overflow crowd at the mall on September 12.

Fountain Construction is almost finished with the demolition work on the second floor of the old Gayfers store, according to executive director Brad Chism. The Medical Center's clinics will occupy the entire 165,000 square feet of what was once the Gayfers store.

Demolition continues on the space to be occupied by the Jackson-Hinds Comprehensive Health Center clinics and the space to be occupied by the city's Office of Human and Cultural Services and the Water-Sewer Administration. The city has set March 15 as a target date for moving in.

In other plans, the foundation has contracted with Entergy to replace all the lights in the mall parking lot. The company will remove the existing lights and standards, replacing them with more lights that are brighter and more energy efficient. This work, according to Chism, is scheduled for completion by Thanksgiving and is part of the foundation's effort to make the property safer for evening visitors. Additional security personnel and cameras should also be in place by August, 1997.

ARS, a woman-owned Jackson construction company, is removing all the old asbestos floor tile and pipe insulation before the general demolition work on the Hinds County Health Department space begins this month.

A $23 million loan from Bank One of Baton Rouge, Louisiana, enables the foundation to pay off three local banks-Trustmark National Bank, Bank of Mississippi and Deposit Guaranty National Bank- that had lent money for the purchase of the mall and approximately $1.8 million to keep construction underway. This is the Louisiana bank's first major lending venture in the central Mississippi market, according to Chism.

Chism also points out that local charity groups involved in renovation of housing for the disadvantaged and elderly or churches and civic groups in the neighborhood that are renovating their facilities have a chance to acquire some of the materials being discarded in the renovation process.

"There are sinks, toilets, water heaters, doors, sets of track lighting, mirrors and panes of glass that have been inventoried for donation," Chism said. "The materials are being given away on a first-come basis, and we ask that only charitable organizations participate."

The foundation, which may be reached at (601)982-8467, is dedicated to the expansion of high quality affordable health care in the Jackson area and to the economic recovery of the neighborhood surrounding the mall.❑

New Members

DERHGAWEN, SANJAY, Hattiesburg. Born Patna, India, August 5, 1961; MD Patna Medical College & Hospital, Patna, India, 1988; medicine residency, St. Thomas Hospital/Akron City Hospital, Akron, OH, 1991-94; nephrology residency, Cleveland Clinic Foundation, Cleveland, OH, 1994-96; elected by South Mississippi Medical Society.

FARRELL, STEVEN E., Hattiesburg. Born Dallas, TX, March 25, 1958; MD University of Texas Health Science Center Medical School, Houston, TX, 1987; medicine residency, Tripler Army Medical Center, Honolulu, HI 1987-90; elected by South Mississippi Medical Society.

FILLINGANE, CHARLES S., Pearl. Born Hattiesburg, MS, November 13, 1958; DO University of Health Sciences, Kansas City, MO 1985; one year internship, Lakeside Hospital, Kansas City, MO; elected by Central Medical Society.

FROMKE, MICHAEL D., Hattiesburg. Born St. Paul, MN, April 16, 1963; MD University of Tennessee College of Medicine, Memphis,TN, 1990; surgery internship, one year, same; neurosurgery residency, same, 1991-96; elected by South Mississippi Medical Society.

GOODYEAR, CONSTANCE M., Wiggins. Born Gandel, Newfoundland, Canada, August 3, 1950; MD McMaster University Faculty of Health Sciences, Hamilton, Ontario, Canada, 1981; family practice residency University of Ottawa, Ottawa, Ontario, Canada, 1981-83; elected by South Mississippi Medical Society.

HELVESTON, WENDELL R., Hattiesburg. Born Mobile, AL, October 17, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; interned and neurology residency, University of Florida Medical Center, Gainesville, FL 1991-95; elected by South Mississippi Medical Society.

LANCASTER, LISA M., Hattiesburg, Born Memphis, TN, May 31, 1966; MD University of Tennessee College of Medicine, Mempis, TN, 1992; interned and pediatric residency, Arkansas Children's Hospital & Univ. Of Arkansas Medical Center, Little Rock, 1992-96; elected by South Mississippi Medical Society.

LAWSON, LOUISA E., Richland. Born Ghana, March 21, 1961; MD University of Ghana Medical School, Ghana, 1987; pediatric residency, University Medical Center, Jackson, MS, 1991-94; elected by Central Medical Society.

PARKER, LARRY M., Hattiesburg. Born Houston, TX, January 11, 1963; MD University of Alabama School of Medicine, Birmingham, AL, 1989; surgery internship, one year, Emory University School of Medicine, Atlanta, GA; orthopedic surgery residency, same 1990-94; one year fellowship, spine surgery, Maryland Spinal Reconstructive, St. Joseph Hospital, Towson, MD; elected by South Mississippi Medical Society.

PHILLIPS, JOSEPH P., Hattiesburg. Born Jackson, MS, April 9, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; medicine residency, University of Arkansas Medical Center, Little Rock, AR, 1991-94; gastroenterology fellowship, University Medical Center, Jackson, MS, 1994-96; elected by South Mississippi Medical Society.

REDMANN, GREG A., Ocean Springs. MD University of Texas Health Sciences Center, San Antonio School of Medicine, 1987; medicine internship, one year, John Hopkins & Sinai Hospital, Baltimore, MD; neurology residency, Georgetown University Hospital, Washington, DC, 1988-89; neurology residency, Duke University Medical Center, Durham, VA, 1989-91; neurology clinical fellow, Johns Hopkins Hospital, Baltimore, MD, April & May 1991; elected by Singing River Medical Society.

SCOGGIN, JOSEPH A., Starkville. Born Moscow, Idaho, December 10, 1964; MD Loma Linda University School of Medicine, Loma Linda, CA, 1991; orthopaedic surgery residency, same, 1992-96; elected by Prairie Medical Society.

SOBIESK, JOHN D., Hattiesburg. Born Oak Park, IL, September 6, 1964; MD Louisiana State University School of Medicine, New Orleans, LA, 1990; interned and otolaryngology, head & neck surgery residency, LSU Affiliated Hospitals, New Orleans, LA, 1991-96; elected by South Mississippi Medical Society.

STEWART, DEANNA K., Hattiesburg. Born Jackson, MS, September 12, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1992; Ob-Gyn residency, University Medical Center, Jackson, MS, 1992-96; elected by Central Medical Society.

DEATHS:

WHITTINGTON, HOMER A., Natchez. Born Centreville, MS, January, 26, 1906; MD University of Louisville School of Medicine, Louisville, KY, 1930; interned one year, Baroness Erlanger Hospital, Chattanooga, TN; surgery residency, Natchez Charity Hospital, 1931-35 & Chicago Cook County Hospital, Chicago, IL, 1938; died August 13, 1996, age 90.

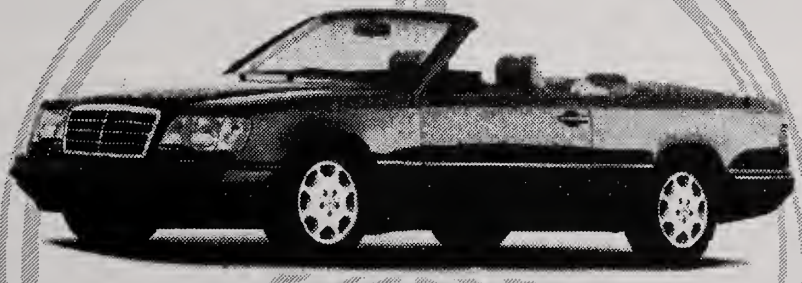
WILLIAMS, M. NEY, JR., Jackson. Born Raymond, MS, December 31, 1921; MD Louisiana State University School of Medicine, New Orleans, LA, 1950; interned one year, Charity Hospital, New Orleans, LA; anesthesiology residency, Ochsner Foundation Hospital, New Orleans, LA, 1954-56; died August 6, 1996, age 73.

WOOD, JAMES P., Waynesboro. Born Clinton, MS, December 29, 1920; MD Tulane University School of Medicine, New Orleans, LA, 1950; interned one year, Charity Hospital, New Orleans, LA; died July 29, 1996, age 75.

NATIONAL HIV TELEPHONE CONSULTATION SERVICE
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Based at San Francisco General Hospital, the "Warmline" provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists, and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 am and 5:00 pm PST. A twenty-four hour voice mail system is available at other times. The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers, and the American Academy of Family Physicians.

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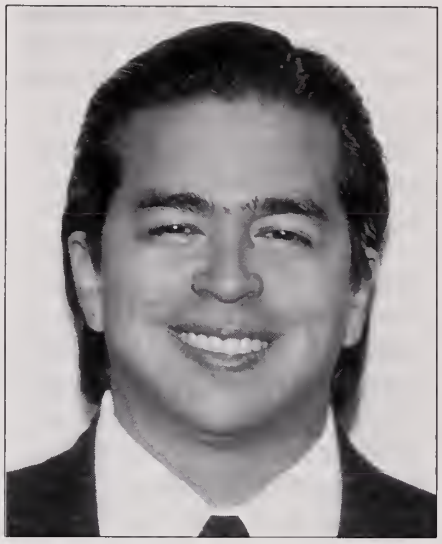
601-984-3700

Personals

Philip J. Kregor, M.D., assistant Professor of Orthopaedic Surgery at the University of Mississippi Medical Center, has been selected as a 1996 John J. Fahey, M.D. Memorial North American Traveling Fellow of The American Orthopaedic Associaton (AOA). This four-week tour will include lectureships at 12 selected orthopaedic centers in Canada and Eastern and Midwestern United States. Dr. Kregor will lecture on pelvic/acetabular fractures, nonunions/malunions, and bone microcirculation. Dr. Kregor was one of five individuals selected for this prestigious fellowship.

Felix H. Savoie, M.D. presented a series of lectures and live demonstrations of surgical techniques at the American Academy of Orthopaedic Surgeons 1996 Summer Institute Intensive Surgical Skills course in San Diego, California. Among the topics were demonstrations of arthroscopic management of shoulder instability and rotator cuff disorders. Presentations were made regarding the management of shoulder instability, disorders of the elbow, wrist and adhesive capsulitis of the shoulder.

Rush Netterville, M.D. is recovering in Marietta, Georgia from a stroke he suffered recently. His address at the time of publication is 1170 Forest Brook Court, Marietta, Georgia 30068-2827.



Stuart A. Yablon, M.D. *(pictured above)* has joined Mississippi Methodist Rehabilitation Center (MMRC) as Director of the Brain Injury Program. Dr. Yablon is board-certified in physical medicine and rehabilitation. Prior to joining MMRC, Dr. Yablon was Co-Director of the Brain Injury Program for The Institute for Rehabilitation and Research (TIRR), of Houston, and Assistant Professor in the Department of Physical Medicine and Rehabilitation at the University of Texas Medical School at Houston, and Baylor College of Medicine, Houston, Texas. Dr. Yablon received his Doctor of Medicine degree from The University of Texas Medical Branch at Galveston. He completed his residency training with the Department of Physical Medicine and Rehabilitation of the University of Medicine and Dentistry of New Jersey/New Jersey School of Medicine, where he served as Academic Chief Resident. He then completed a two-year Rehabilitation Research Center Development Fellowship at Baylor College of Medicine and the Brain Injury Program at TIRR, specializing in Brain Injury Rehabilitation.

James V. Ferguson, Jr., M.D. announces his retirement from full-time practice at Greenwood Leflore Hospital. He is available for second opinions and consultations by calling (601)453-6440.

Wendell R. Helveston, M.D. and **Michael D. Fromke, M.D.** have joined Hattiesburg Clinic in the practice of neurology with Marc S. D'Angelo, M.D., Geoffrey B. Hartwig, M.D., Keith W. McLarnan, M.D. and Mark S. Puricelli, D.O. Dr. Helveston received his medical degree from the University of Mississippi School of Medicine in Jackson. He then completed a residency in neurology at the University of Florida in Gainesville. Dr. Helveston has also completed an EEG epilepsy fellowship at the University of Texas Health and Science Center in Houston. He is a member of the American Medical Association, American Academy of Neurology and the American Epilepsy Society. He is board-eligible in neurology. Dr. Fromke received his medical degree from the University of Tennessee in Memphis and then completed a residency in neurosurgery there. Dr. Fromke is a member of the American Association of Neurological Surgeons, the Congress of Neuro-

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

logical Surgeons and the American Medical Association. He is board-eligible in neurosurgery.

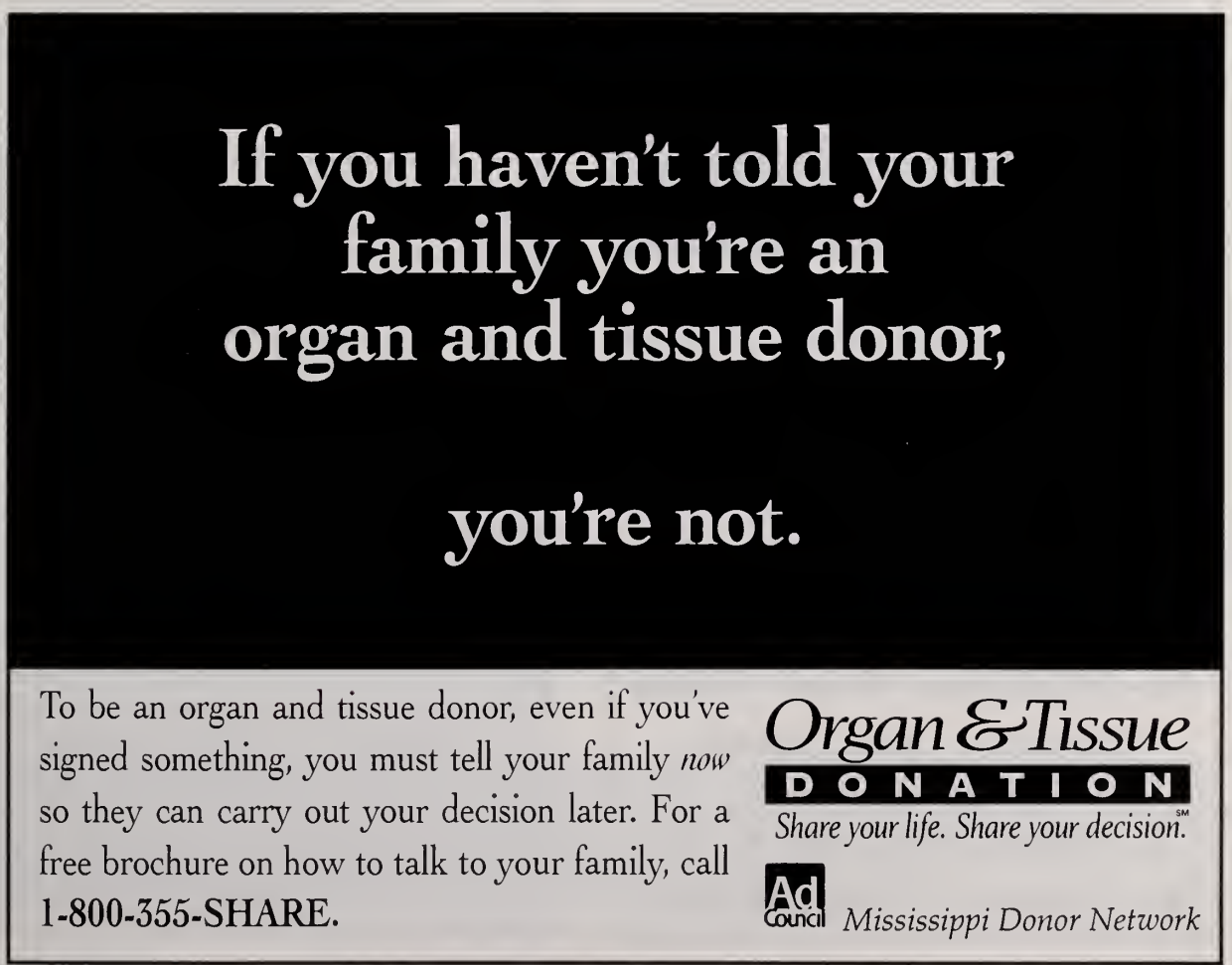
Lisa Mosher Lancaster, M.D., joins the Children's Clinic, a service of Hattiesburg Clinic, in the practice of pediatrics with Frank E. Dement, III, M.D., S. Kimble Love, M.D., Margaret E. McKenna, M.D., and Susan L. Robbins, M.D. Dr. Lancaster received her medical degree from the University of Tennessee College of Medicine in Memphis. She then completed a residency in pediatrics at Arkansas Children's Hospital at the University of Arkansas for Medical Sciences in Little Rock. She is a member of the American Academy of Pediatrics and the American Medical Association. Dr. Lancaster is board eligible in pediatrics.

Prentice J. Walker, M.D. has joined Lumberton's Family Health Services Clinic. Dr. Walker comes to Lumberton from Hattiesburg, where he was a staff physician at the Urgent Care Center. A native of Hattiesburg, Dr. Walker is a graduate of the University of Southern Mississippi. He received his medical degree from Louisiana State University before completing his internship and residency in Detroit, Michigan.

Sidney J. Dedeaux, M.D. announces the opening of PrimeCare of Pearl, Incorporated at 148 South Pearson Road, specializing in family care.

D.E. Magee, M.D., a Jackson opththalmologist and longtime Republican, has been nominated by Governor Kirk Fordice and confirmed a member of the state College Board.

Gregory A. Redmann, M.D., board-certified neurologist, announces the opening of Gulf Coast Neurology Clinic, P.A. in Ocean Springs for the treatment of headaches, strokes, seizures, pinched nerves, back pain, neck pain and general neurology. Dr. Redmann is pleased to be returning to his hometown to practice medicine.



Placement Service

IM/FP Physicians needed to staff clinics in Jackson, McComb, Tupelo and other areas. **Call Russ Offerle, Southern Healthcare•(601) 982-3336 or 800-880-2772.**

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If you have staffing needs anywhere in the State of Mississippi, Temporary or Permanent, call on Southern Healthcare for Physicians, Nurses and medical office personnel. **Call: Joyce Wright, Angela Vinson, or Russ Offerle, (601) 982-3336 or 800-880-2772.**

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Journal MSMA Placement ads are $2.00/line, with a 4-line minimum charge of $8.00. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing.

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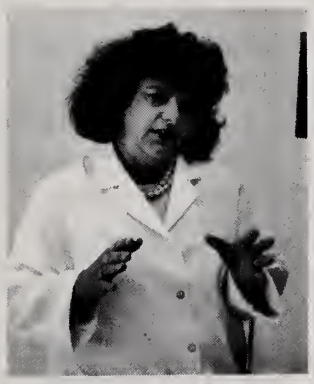
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Nancy Dickey, MD
AMA Board Chair discusses Physician-Assisted Suicide



Photos by: Ted Grudzinski

What is the AMA's overall position on the issue of physician-assisted suicide?

Physicians are devoted to healing and to relieving suffering. As your doctor, I am obligated and committed to helping you in your remaining days. I cannot be the cause of your death, nor can I assist you in causing your own death.

What is the AMA's underlying concern on this issue?

The heart of our concern is placing physicians in the position to actively end their patients' lives. My patients must know wholeheartedly that I am devoted to their health and welfare, not deciding their fate based on what I, or others, might perceive to be the value of their remaining life. Make no mistake, when it comes to caring for my patients' health and welfare, I am their trusted ally.

Does the AMA's Code of Medical Ethics represent all physicians?

Like all individuals, physicians do have a range of personal opinions on various issues. However, the Code of Medical Ethics, which is maintained by the AMA's Council on Ethical and Judicial Affairs, is widely followed throughout the country. It is cited regularly by State Medical Boards when determining standards of practice for the medical profession. In addition, the AMA's House of Delegates reviews and approves all ethical opinions contained in the Code of Medical Ethics. Because the House of Delegates represents, in one way or another, nearly 98 percent of the physicians in America, the Code of Medical Ethics is truly representative of



medicine's position with regard to ethical opinions.

How do you respond to critics who say the AMA's position on physician-assisted suicide does not consider patient fear and desire for dignity at the end of life?

Fear associated with physical suffering, with losing control, with being a burden to or dependent upon family members, and with losing dignity is an understandable reality. The medical profession has not concentrated on these issues to the necessary degree. But, we feel the appropriate alternative to physician-assisted suicide is improved care through a better informed medical profession and public, working together to ease the dying process. I will use all of my skill and knowledge to relieve your suffering, I will get you the help you need to come to terms with death. But, I cannot help you kill yourself.

How does the AMA distinguish between controlling pain even if it causes death and assisted suicide?

The distinction is based on the intent of my actions. I am acting in the best interests of my patient if, while attempting to control suffering and maximize his or her comfort, death is hastened.

However, if the intent of my actions goes beyond comfort and focuses specifically on causing death, I am either assisting in suicide or performing euthanasia, both of which are unethical.

Isn't that a fine line?

In some cases it may be a fine line. Usually, however, the intent is very clear. Regardless, if a line is to be drawn, intent to comfort vs. intent to kill is one line physicians must not cross.



How does assisted suicide through pain medication differ from death caused by removal of treatment/life support?

In the case of a patient whose life is artificially extended by technology, they and their family, in consultation with their physician, may decide to withdraw that life support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy and dignity. Again, the issue is one of intent. By removing artificial life support, I am honoring my patient's wish to allow natural death to occur. My intent is to avoid prolonging artificially-sustained life, not to cause death.

How do you respond to recent court decision in California (9th Circuit), which states that physician-assisted suicide is a Constitutional right?

First of all, nowhere in the Constitution does it state that individuals have a right to have their doctor kill them if they so choose. We find this interpretation to be rather illogical. Second, these and future rulings do not change the ethic of the medical profession which clearly states that physicians should not assist in suicide.

Will the AMA appeal these and other Court decisions?

We will do whatever is necessary to ensure that physicians are not put in a position to kill, and that patients die in comfort and with dignity. If this means appealing directly or submitting amicus briefs or offering verbal



or written testimony in support of an appeal, we will do so. In addition, the AMA is mounting a major information-based campaign to educate and inform the courts, the media, physicians and the general public about the alternatives to physician-assisted suicide, including hospice care.

Will the AMA consider changing its policy regarding physician-assisted suicide?

We will continue our discussions with those whose opinions differ from ours. We will aggressively increase our efforts to educate physicians at all levels in treating physical pain and the psychological needs of patients at the end of life. We will work diligently to enlighten patients on the alternatives to physician assisted suicide, including hospice care. However, the related ethical opinions developed by the AMA's Council on Ethical and Judicial Affairs will remain unchanged.

How does the AMA feel about the $10 million defamation suit brought against you by Jack Kevorkian.

Let's make a distinction here. Notwithstanding our position on physician-assisted suicide, Jack Kevorkian's actions are reprehensible. Even most proponents of physician-assisted suicide are appalled by his activities. Abandoning bodies in parking lots falls well short of our societal expectations for death with dignity. With regard to the lawsuit, we feel that it is nonsense. We will not be silenced on an issue so critical to the welfare of our patients. ◆

Interview by Mark Wolfe

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Jennifer Corson at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE
Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

INSURANCE/FINANCIAL/RETIREMENT PROGRAM
MSMA members have available several insurance plans designed exclusively for physicians. Through the "group" buying power of the association the plans can usually be obtained at lower cost and there is the advantage of "one stop" coverage. For further information contact Executive Planning Group.

MEDICAL MALPRACTICE INSURANCE
The Medical Assurance Company of MS (MACM) was sponsored and organized by MSMA in 1976 to provide a stable market for medical liability insurance to eligible physicians. The Company currently has 2000 policy holders. Extensive physician leadership is involved in all phases of MACM's operations. For further information call MACM.

MSMA and MSMA Diversified Services - 735 Riverside Drive, Jackson, MS 39202-1166; 601-354-5433 or 800-898-0251 (In-State-WATS).

AMA Purchase Link - 800-772-4346.

AMA and AMA Membership Hotline - 515 North State Street, Chicago, IL 60610; 800-AMA-3211.

Mississippi Physicians Insurance Company - P.O. Box 5229, Jackson, MS 39296-5229, 601-354-5433 or 800-898-0251 (In-State-WATS).

Medical Assurance Company of Mississippi - P.O. Box 4915, Jackson, MS 39296-4915, 601-353-2000 or 800-325-4172 (In -State-WATS).

Executive Planning Group, P. A. - 601-982-3000 or 800-898-0954 (In-state-WATS).

MISSISSIPPI STATE MEDICAL ASSOCIATION

Membership Services

When you need information on a specific subject or association service, the following MSMA staff person(s) are available to assist you.

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- **Scientific Exhibits** • Charles Mathews
- **Technical Exhibits** • Charles Mathews
- **Meeting Schedule** • Charles Mathews

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Component Medical Societies • Barbara Shelton

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Dues (MSMA & Alliance) • Barbara Shelton

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Insurance Form Orders • Vickie Potter

Journal MSMA • Karen Evers

Legislative Activities • Charmain Thompson

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MS Physicians Care Network - Charles Mathews

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Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

Key Words should follow the abstract and be identified as such. Provide three to five key

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Subheads are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

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From "Doc" on Horseback to Managed Care- In Commemoration of the 140th Anniversary of the Mississippi State Medical Association

Karen A. Evers, Managing Editor

"The more things change, the more they remain the same."
-Alphonse Karr

Preface

In recollection of the yesteryears and yesterdays that made the Mississippi State Medical Association what it is today, we pay tribute to the Association's 140th Anniversary. The managing editor wishes to acknowledge the official MSMA historians, Drs. Ewing Fox Howard and James Grant Thompson. The portions of the history covering the Transactions of the House of Delegates and officers of the Association from 1856 to 1910 were written by Dr. Howard and published in 1910. Dr. Howard continued to compile information for a second edition until his death in 1933. Further material covering the period 1933 to 1948 was published in a 1949 volume dedicated to Dr. Howard. The author of the second edition was Dr. Thompson who served as MSMA historian from 1944 to 1950. A third edition, dedicated to Dr. Thompson and covering the period 1951-1982, was compiled by direction of the Board of Trustees in recognition of the 125th Anniversary year of the Association. It is my intent to be inclusive by accurately calling upon the material which they preserved and also to build upon their archives. No doubt, what the historian recorded was of utmost importance at the time in the scope of promoting organized medicine. However, some of the more fascinating observations can only be appreciated with the passage of time.

Introduction

If you think it is difficult today, understanding managed health care plans and other nuances of medical practice, would you trade the advancement of modern medicine for the days of the frontier physician or country doctor?

Imagine country practice: First, there is the issue of transportation; how do you get to the patient? Second, the act of conducting oneself in the patient's home. And then, what one did after he arrived at the bedside of the patient.

My father, a sort of Northerner-come-Southerner, academic physician, who taught me many things but always from a physician's point-of-view and usually with a lesson to them, used to talk of days-back-when.

In kindergarten carpool I remember making fun of his first car, the one he drove from Minnesota to Mississippi to do his residency, a '59 Chevy Impala or the Black Bomb as we called it. "You know, when doctors before me began any practice the means of transportation preferred (in the order named) was: horse or team and buggy;

horse and road cart, a two-wheeled vehicle with a simple and very hard back seat; horseback and finally walking it," he retorted. "I suppose you could have ridden a bicycle," I replied. "Yes, if the snow wasn't too deep and the roads were good and the distance not so long, I suppose you could."

Children of doctors will recognize that story, if not for the details then for the attitude. It's the same attitude that gives us something in common...growing up knowing we would never have any sympathy for what ailed us; sympathy was for the patients. But we all admire doctors, and we feel proud that our fathers made a living helping people.

Doctors from generations of doctors have probably heard similar stories: When the roads were extremely muddy the road cart had its advantages. The pull on the horse was considerably less and one could dodge in and out and past mud holes and it was easier to cross the fields because one could make short turns. Besides if one turned over it was easier than the buggy to right again. When the horses and mules gave out, the country doctor walked.

Even with the invention of the automobile the doctor was often inconvenienced by being given the wrong directions by an excited person. As one doctor recalled when asked about his experience with wrong directions, "I was told to go to a certain town forty miles distant, then eight miles east and then eight miles south. I did so but when I arrived in that neighborhood no one knew the parties. I suspected the nature of the mistake. I retraced eight miles and found a small country store still open though it was eleven o'clock at night. No one knew such a party, in fact knew of no one sick. Then a little girl about eight years old, sitting unobserved in a corner, gave me the proper directions. The child had heard her mother and some neighbors discussing the serious sickness of some acquaintance. Let those who will scoff at women's clubs; they were called quiltings in those days. Had it not been for the gossip of her elders this little girl would not have known of the illness of the neighbor. At any rate I found the place all right, a very sick man and a very anxious family. As it was I arrived only in time to predict that he would be dead before morning. Of course having been unable to be of any service I was not entitled to any pay. This was one of my first trips in an automobile, that is if the old chain-drive Cadillac was an automobile? The chain broke eight times on this trip. But the trip was made in record time, one hundred and twenty miles in fifteen hours, eight dollars to the owner for the use of his car."

Ever try delivering an infant in the dark? There were many trials in attending labor cases. This one stands out. "The patient was nearly forty years of age, small, chunky. A glance indicated that a difficult job was ahead. Only the husband was with her. The night was stormy. As soon as I arrived the husband, a half-wit, departed for a destination unknown and I was left alone with the patient. There was a little stove and a basket of corncobs. After a delay of many hours it became evident that instruments would be required. I had no anesthetic. The patient was in great distress. Her intelligence was just one jump ahead of her husband's. It was necessary to get on the bed and hold the patient's legs with my knees while I applied the forceps. I finally got a fine boy."

"Trying to wash a new baby is some sleight-of-hand job. Naturally, I had no lap so I would place the object of my efforts on the kitchen table, which was invariably covered with oil cloth. These youngsters are as slick as greased pigs. So, in order to prevent the baby from falling to the floor I was obliged to grasp one leg firmly with one hand, which left only one available for performing the ablutions. After a few such experiences I carried a bottle of sweet oil and just anointed it all over, rolled it in whatever was available and allowed it await the ministrations of more experienced hands."

Today, when the topic turns to medicine's cutting edge, the physician house call seldom comes up though the American Medical Association is trying to change that. The contemporary discussion is likely to be about integrated delivery systems and managed care companies, telemedicine consultations, acquired immunodeficiency syndrome (AIDS) prevention, or the Food and Drug Administration's guidelines addressing animal-to-human transplants .... topics unknown to those physicians who founded the Association in 1856.



W. Y. GADBERRY, Yazoo City.
PRESIDENT 1858.

PREFACE

From the First Edition

When the writer was elected Secretary of the Mississippi State Medical Association in 1907 and the paraphernalia of the office was turned over to him by his predecessor, he was struck by the entire absence of records. There was not even a file of the official transactions, due to the fact that at least twice the secretary's office had been wiped out by fire. He endeavored to obtain these records by applying to various of the older members, but while all of them were glad to lend books temporarily, some of them, from perfectly justifiable sentimental reasons, were unwilling to give them up for all time. Right here the secretary conceived the idea of abstracting from the various volumes of *Transactions* such items as struck him as being of particular interest and preserving them by publishing them in a more or less connected form in the *Mississippi Medical Monthly*. He had hardly begun this when there dawned the idea of a more comprehensive work that would more completely tell the story of the Association. Later the material collected was offered to the Association, which appointed Drs. H. L. Sutherland of Rosedale and J. C. Hall of Anguilla to collaborate with him and from them he has received help and advice that have gone far towards adding to the merit of the book and remedying its crudities. Acknowledgment is also made of the hearty encouragement and unstinting aid received from various other physicians in working up many of the details. Even after three years' work the book is by no means complete or perfect, but it represents the best that the very inadequate material and ability could produce and is offered without apology for the reason that it is a labor of love and an attempt to in some measure rescue from oblivion the work of the pioneers in medicine who laid the foundations of the Association.

E. F. HOWARD.
VICKSBURG, MISS., June 10th. 1910.

History of the Mississippi State Medical Association

* "The first meeting of the Association was held in Jackson December 15th, 1856. It was organized by electing Dr. W. Y. Gadberry of Benton president and Dr. M. S. Craft of Jackson recording secretary. The meeting was composed of Drs. Gadberry and Craft; Drs. S. C. Farrar and A. B. Cabaniss of Jackson; H. Posey of Brandon and C. B. Galloway of Kosciusko; with perhaps others whose names do not appear in the proceedings. A Constitution and Bylaws were adopted and delegates appointed to the American Medical Association. On motion of Dr. Craft, those physicians who signed the call for this convention were declared permanent members on compliance with the Constitution and Bylaws.

The Association adjourned to meet on the second Monday in November, 1857, but there was no other meeting until April 20, 1869, when, in pursuance of a call made by the Vicksburg Medical Society, physicians from various parts of the state assembled in the city of Jackson for the purpose of forming a State Medical Association. Dr. A. B. Cabaniss was called to the chair and Dr. Ed. Lea, of Winona, appointed secretary. Reorganization was effected by the election of Dr. E. T. Henry, of Vicksburg, president and four vice-presidents in the order named: Thos. D. Isom of Oxford, E. G. Banks of Clinton, S. V. D. Hill of Macon, and Wm. Compton of Holly Springs. Dr. Ed. Lea was elected recording secretary, Dr. M. S. Craft corresponding secretary and Dr. P. T. Bailey, of Jackson, treasurer. Much important business was transacted at this meeting, which was really the beginning of the Association. The Constitution and Bylaws of the former meeting were readopted with a few unimportant changes. The following were elected delegates to the American Medical Association, to meet in New Orleans: Drs. F. W. Dancy, S. B. Cutler, W. Y. Gadberry, M.S.Craft, Robert Kells, Jas. R. Barnett, K. C. Devine, P. F. Whitehead, Ed. Lea, E. T. Henry, H. C. McLaurin, W. B. Williamson, C. B. Galloway, S. V. D. Bill, _____ Martin, T. D. Isom, F. Hughes, B. F. Ward, A. Thomas, J. S. Davis, L. Lipscomb, J. P. Moore, Gus. Evans, J. G. Thornton, A. G. Mayers, J. M. Greene, A. S. Snell, A. H. Smith, Wirt Johnston, _____ Lyle, D. A. Kinchloe, _____ Harper of Natchez, and J. J. McLean of Union Church.

***From a letter by Dr. J. M. Taylor, president in 1873-4, published in the *1893 Transactions*.**

On motion of Dr. Barnett, a committee was appointed to prepare an address to the medical profession of the state, urging the importance of speedy organization of county or local societies; and, on motion of Dr. Hill, a committee was appointed to prepare an address to the people of the state respecting the importance of a more perfect system of drainage upon plantations, with a view to as far as possible arresting the production of miasma, so fruitful as a source of grave forms of fever.

Chairmen of committees were appointed, also, to report at the next meeting on important medical subjects. The Association adjourned to meet at Vicksburg on the first Monday in April 1870.

Pursuant to adjournment, the Association met in Vicksburg, April 4th. 1870. Several interesting cases were reported. A tumor, removed the day before by Dr. Baird, of Yazoo County, was exhibited. Dr. Hunt, of Vicksburg, reported the removal of an ovarian tumor. Dr. Booth, of Vicksburg, reported a case of aneurysm of the ascending aorta, which had caused absorption of part of the sternum and ribs. Dr. Hunt also reported a case of anchylosis of both maxillary bones relieved by operation. Dr. D. B. Nailor, of Warren County, reported a case of abscess of the right lung, simulating aneurysm. Dr. Hill reported a case of atresia vaginae in which no uterus could be found and Dr. Balfour a similar case in which the catamenia had appeared in girlhood but had not returned for twenty years.

On motion of Dr. Steinside, a committee (Craft, Mitchell and Baley, of Jackson) was appointed to memorialize the legislature to appoint an examining board to examine all persons proposing to practice medicine in this state. Officers elected for the ensuing year were: S. V. D. Hill, president; A. B. Cabaniss, D. B. Nailor, 0. B. Galloway and B. F. Kittrell, vice-presidents; Dr. McConnell, recording secretary; J. R. Barnett, corresponding secretary; W. Y. Gadberry, treasurer. The Association adjourned to meet the next year in Meridian.

Medical organization was by no means at a premium in these early days. The proceedings for the next three years are only recorded in a vague way, in the memory of a few of the older members. Meetings were held, but little was accomplished. The membership was small and only the faithful few who attended regularly seemed to be at all interested.

This lack of interest was so evident that in **1874** not only did the program fall rather flat, most of the essayist being conspicuous by their absence, but the finances were in such bad shape that a committee was appointed to ask an appropriation of three hundred dollars per annum from the legislature to defray the cost of publishing the *Transactions*. It seems rather a remarkable argument in favor of the statement, so often made, that "history repeats itself" that at this meeting was adopted a resolution demanding a five dollar fee for insurance examinations.

In **1877** the meeting was held at Grenada. At this meeting, the first definite, authentic record of the efforts made by the Association in matters of public health, the report of the executive committee on this occasion is interesting: "After consultation...it was decided to apply to the Legislature for the passage of an act to establish a State Board of Health. Accordingly a bill was presented at the last session of the Legislature, which after being completely emasculated and radically altered, was passed, a copy of which, as passed, is herewith presented. It is needless to say that, in present form, the law is worthless to the State. The present law should be regarded merely a permissive act your committee believes it may be made available in ultimately accomplishing the objects sought. It may be fairly presumed that the law will be amended and made effective whenever its capacities and benefits shall be demonstrated and fully appreciated." The committee also urged the presentation to the Legislature of a registration act, providing laws for the collection of vital statistics, and advised against the introduction of any bill regulating the practice of medicine.

For the purpose of benefiting the work of the Association itself and increasing its membership, the committee suggested an organization, with county and local societies as integral parts, similar to that effected in 1903, but no definite plan was suggested and no action taken.

At this meeting there were selected as members of the Board of Health of Mississippi, created by the Act above commented: 1st. Congressional District, J. M. Taylor and A. G. Smythe; 2nd., T. D. Isom and John Wright; 3rd., E. W. Hughes and S. V. D. Hill; 4th., O. B. Galloway and P. J. McCormick; 5th., Robt. Kells and C. A. Rice; 6th., R. G. Wharton and P. F. Whitehead.

The State Board of Health, thus formed must, in spite of the criticisms on its powers by the executive committee, have found some work to do, for we find in the minutes of the **1878** meeting, which was held in Jackson, a resolution appropriating twenty-five dollars to pay for some copies of its "First Annual Report" for distribution among the members.

The Aberdeen meeting in **1879** must have been an occasion of sorrow for those who attended. Some twenty members, nearly ten percent of the total membership, had fallen in the great yellow fever epidemic of 1878 and the first day of the meeting of the Association was set apart for memorial exercises. Music for the occasion was

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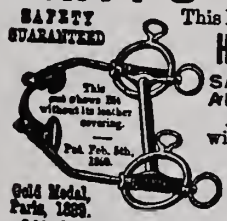
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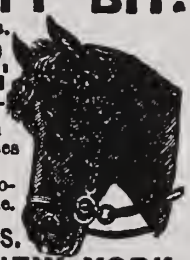
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*Advertisements from the first issue of **MISSISSIPPI MEDICAL MONTHLY**, May 1906, Volume XI, Number1. A few other advertisers in the **MISSISSIPPI MEDICAL MONTHLY*** ninety years ago *include: A. B. Wagner, "the practical undertaker and embalmer" with Wagner, Wyatt & Chatfield Furniture and Funeral Goods, Meridian; and advertiser William R. Warner & Co.s founded 1856 Philadelphia and New York. Their ad asked physicians to mention their name when ordering or filling prescriptions. Their drugs included: Pil. Sumbul Comp. and Lady Webster Dinner Pills, Bromo Soda and Bromo Lithia pills "for nervous and hysterical women, excessive study, migraine, nervous debility, mania and gouty diathesis."*

furnished by the Aberdeen Harmony Club, there was a prayer by Bishop Paine, a lesson read from the Scripture by Rev. V. W. Shields, a memorial address by Rev. B. M. Palmer of New Orleans, memorial poems by Dr. J. Dickson Bruns of New Orleans and Major S. A. Jonas of Aberdeen, a memorial oration by Dr. Jno. Brownrigg of Columbus, the report of the committee on necrology by Dr. A. G. Smythe of Baldwyn and special tributes to deceased members by various of their fellows, the exercises concluding with benediction by Rev. Jno. H. Scruggs.

The Congress of the United States was invoked in behalf of a more efficient quarantine system and an application was made to the Legislature of the state for an Act incorporating the Association.

At the **1880** meeting, in Vicksburg, the executive committee reported that it had attempted to secure from the legislature a law not only incorporating the Association but making it the board of examiners and licensing body to regulate the practice of medicine in the state. This proposed law had been introduced in the senate at the previous session of the legislature and referred to its committee on judiciary, in which committee it was allowed to sleep until the session was over. The committee presented a draft of the bill for comment and approval. This report was accepted and the matter left in the hands of the committee, which was by no means idle, for it reintroduced the subject the next year, at the **1881** meeting at Winona, urging strongly the need of a medical practice act and requesting the members to bestir themselves and assist in the efforts to procure such legislation. That this was not all idle talk is shown by the report of the committee at the Oxford meeting in **1882**, which formally presented the results of its labors in the shape of a medical practice act that had been passed a few months previously by the legislature. On the suggestion of Dr. W. F. Hyer of Marshall county, a member of the executive committee and also of the upper house of the legislature, the proposed charter had been separated from the practice act and a draft of a charter was submitted for approval by the Association, and one of a revised constitution and bylaws, necessitated by the provisions of the charter. The report and drafts were published in full in the *Transactions* of the meeting in order that they might be fully studied and considered by the members.

At the **1883** meeting, at Meridian, the proposed charter, constitution and bylaws were considered and adopted.

The Association met in West Point in **1884**. A committee on prize essays was appointed and a prize of one hundred and fifty dollars offered for the best original essay, based on "experimental or chemical observations", the contest to be open to members of the Association and the offer to be made annually. There is no record that this prize was ever awarded.

Fifty dollars was contributed from the treasury towards the J. Marion Sims Memorial and two members of the Association were appointed a committee to solicit subscriptions to supplement this donation.

In **1885** the Association went to Greenville, and here we find it for the first time interesting itself in hospital matters, a committee being appointed to memorialize the legislature "to appropriate sufficient funds to defray the expense of the Vicksburg hospital".

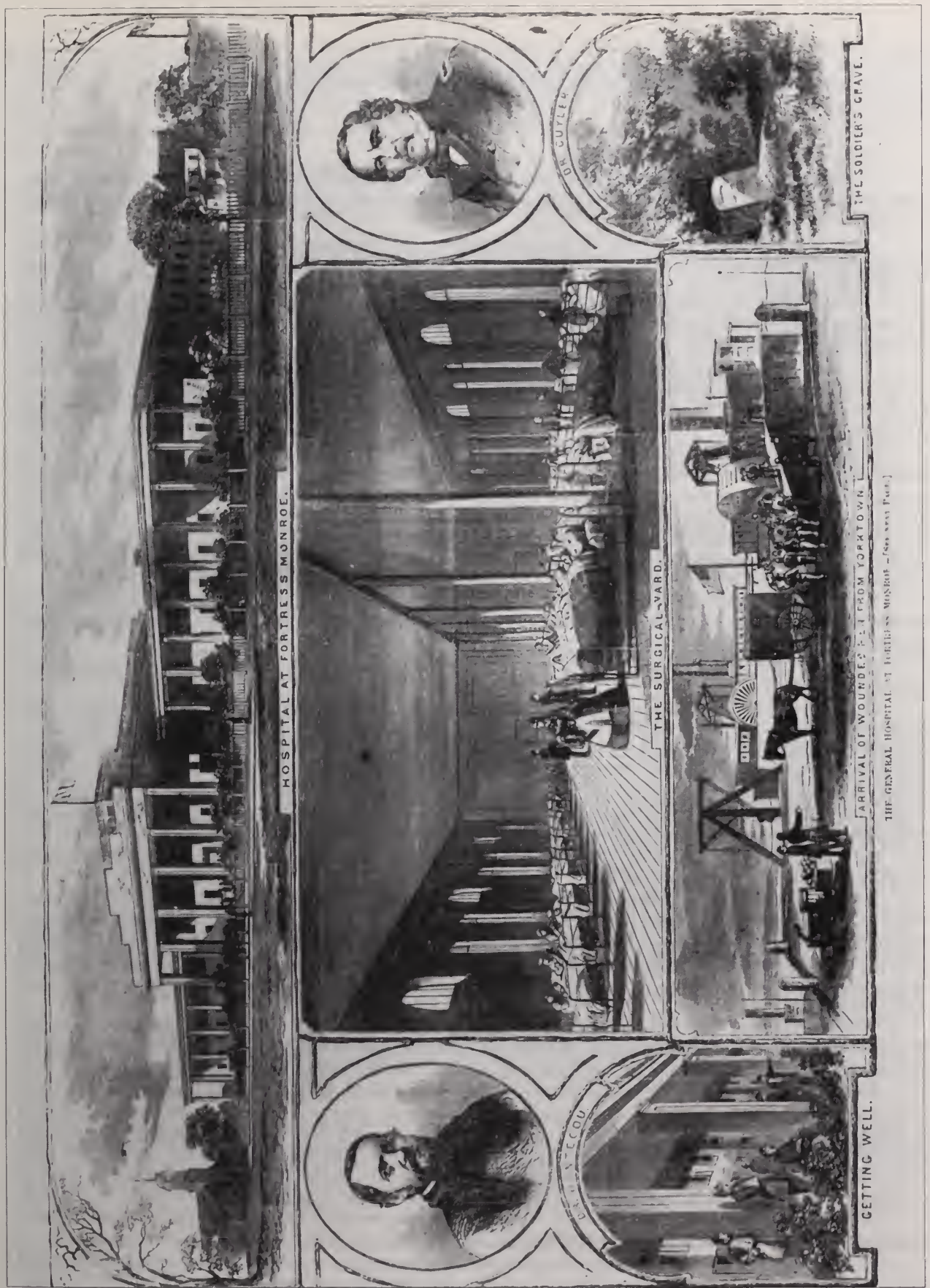
The **1886** meeting was held in Jackson, which was on this occasion adopted as the permanent home of the Association, a resolution being adopted that a two-thirds vote should be necessary to carry it elsewhere. The following year, **1887**, we find the president, in his annual address, advocating the establishment of a State Medical Library and Museum and a committee appointed to perfect plans for such an establishment, but, like so many of the good suggestions made by the Association, no results were ever achieved. A record of a contribution of fifty dollars toward defraying the expenses of the International Medical Congress, made at this meeting, shows that the Association could see beyond the borders of its own state and that its members were alive to the benefits of medical meetings.

In the minutes of the **1888** meeting is found a record of an attempt at the prize offered in 1884 for an original essay, but no award was made on account of failure to comply with some of the requirements. An effort was made at this meeting to obtain from the legislature a law preventing undergraduates from practicing.

By far the most important work in medical legislation yet undertaken by the Association, with the possible single exception of the original medical practice act, was inaugurated at the **1889** meeting, having its origin in a paper by Dr. B. F. Kittrell. The practice act passed in 1882 had proven unsatisfactory in that it had created several boards of examiners and now it was decided the time was ripe to attempt the passage of an act creating one general examining board at this meeting.

There was also entered a formal protest against a ten dollar tax imposed by the 1888 legislature on physicians. A committee was appointed to securethe repeal of this law and satisfactory results were reported at the next meeting.

In **1890** the Association decided to abandon its permanent home and meet the year following in Meridian. In the minutes of this meeting we find recorded one of the quaintest relics of the methods of older days to be found



Civil War Plate with medical scenes from the June 7, 1862 issue of Harper's Weekly. Fortress Monroe is where Jefferson Davis was imprisoned upon surrender. Printed with permission, MS Dept. of Archives & History.

1887 PRESIDENT'S ADDRESS

Fellows of the Mississippi State Medical Association:

Those who live upon the banks of the Mississippi River, upon whose broad current floats the commerce of the Southwest, observe the great steamers as they sound their signals of greeting, come along side, and exchange words of cheer, items of voyage and cautious of dangers to be avoided.

How like these marine greetings are our annual convocations. We here exchange our heartfelt congratulations of health and happiness, or grasp the hand of sympathy in misfortune. We come together, not as a congratulatory assembly merely, but as guards on duty to signal the ills that afflict humanity, and to counsel for their defeat.

To plan effectually we must have harmony of action and concert of purpose. Duty calls for us to consult; not duty only, but the ambition and pride of profession, the love of our cause, the sympathy of our fellows, the respect we have for each other's attainments; last, but not least, that golden mead in which the champions of every cause glory--success.

Now in contrast stand the sessions of 1869 and 1887. At that meeting a few noble, true and determined of our number, ere the smoke of battle had lifted from the horizon and the stains of sacred blood had been washed from historic fields, and under the inspiration of that spirit of good to mankind, re-laid the foundation of this now grand superstructure the State Medical Association.

Today, with thorough organization, we gather under its banner, and success is blazoned on its folds; our joy is blended with sadness while we realize that many of our co-laborers have fallen by the way. But we cherish the hope that they have entered into that rest which awaits all those who truly love their fellowmen. Let us on this occasion strive to embalm their memory by emulating, their virtues. Let the recollection of their noble actions and self-sacrifice set the cement of brotherly love and fraternal regard between us, and make the deliberations of this session noted for that high-born courtesy, characteristic of the profession we represent. Ours is as noble an art as any that taxes the intellect of man. At all times, in all seasons, under every variety of circumstances, our ministrations are sought.

The summer's heat, the winter's cold, day and night alike, witness our labors, and attest our fidelity. Our duties begin with the first feeble breath of the newborn infant, and we are the watchful sentries through all the eventful struggle between life and death, until the great physician shall dismiss the guard.

The profession of medicine should of itself inspire its votaries with motives so high and aims so pure, that its title should be a synonym of honor.

In this retrospective contrast of our twentieth session with that of our re-organization, we see much for self-gratulation and honest pride. Our growth has been eventful, but progressive. The barriers overcome along the way are better known to those whose furrowed brows and silvery locks betoken the struggle through which they have passed. Now, in the victorious noon, it would mal appropos to note in detail each achievement and triumph, and offer to its respective champion that mead of praise so justly due if time would permit. I will, however, venture to vouchsafe to the seniors amongst us, who have so wisely planned and pressed towards completion the grand work of this Association, that regard and veneration which belongs alone to the successful hero, and to bespeak for these veterans to the younger and progressive members, words of encouragement and confidence.

Let us then, like a true brotherhood, come together and clear the deck (pardon the figure) of all obstructions and be ready for action, for we have yet much to accomplish.

We are in the midst of an era of prosperity hitherto unknown to our country. The South is attracting the attention of the whole world. Its importance is being augmented every day by the discovery of hidden sources of wealth, and magnificent possibilities. The bonds of a severed Union are being strengthened by the intermingling of representatives of the various sections in the pursuit of business and pleasure. We are indeed awakening to a grand future. Our lofty mountains with peaks towering into etherial space have slept, Rip Van Winkle-like, for centuries. They are just now quickening into life and will deliver unto us their immense wealth of minerals.

Our own grand State, bordered on the west by the great artery of commerce, with its rich alluvial bottoms, and on the east by fertile prairies, while her pineries, the finest in the world, awaits only the advent of capital and the honest immigrant to stir her into renewed life, and she will assume first magnitude in the galaxy of stars that now glitter in the Southern horizon.

In this new order of things what part shall the medical profession of Mississippi play? Shall we remain in the rear of the march of prosperity, or go to the front? That we play no little part in the grand make-up in a State's advancement and prosperity, is universally conceded. Shall we prove recreant to the duties? Although we stand today as a strong aggressive body, endorsed thoroughly by our State in the grant of the high prerogative in naming the members of the State Board of Health, to whom, as sanitary commissioners, the expenditure of a large appropriation has been entrusted; yet we have much to do. To enhance and perpetuate its growth and widen its sphere of usefulness should be the labor of every member of this Association.

Cheering indeed is it to note the progress we have made in protective medicine. Without those powerful auxiliaries- Medical Journals-to combine action, we have made such strides as to rank us first among the Southern States in achievement.

The tide of sweeping pestilence has been stayed and the populace measurably protected from the impositions of the charlatan, empyric and mountebank. This, in the nature of things, has elevated the tone of the profession throughout the State, and invigorated the esprit de corps of the Association. But with all this, to pause here would be poor tribute to the memory of Whitehead, Hall,

Compton and Henry, whose labor till death was in this work of love. There are yet with us members of the old guard, whose spirits would chaff at hesitancy or inaction. The wisdom of Taylor, Kittrell, Kells, Hill and others would frown upon any policy other than the aggressive. The vigilance of Johnston, ever on the watch tower, would signal the danger of inactivity. The clarion tones of our *invincible* Hyer would ring with *withering scorn* at every signal for retreat and would call the clans together, and would lead them, if necessary, in the very jaws of death.

No, Fellows, we cannot, must not pause! We must go on! Science demands it, humanity demands it, the State expects it. Hope beckons to brighter and fairer meads of triumph.

Every county in the State is an open field to occupancy, and cultivated by the organization of Medical Societies in them all, would enhance your power for good.

Some resolution or action looking to this end, I would urgently recommend. In many portions of the State there is yet an apparent, if not a real lack of interest, on the part of the profession in this cooperation. But may we not reasonably hope that with the Association domiciled at the capital of the State, and with increased facilities for travel, we may have representation from all sections? Even should the local societies hinted at have no direct connection with us, by being supplied with our *Transactions*, they would soon grow into active sympathy and become co-workers, not only in the interest and advancement of State medicine, but valuable contributors to the literature of our Association, and to the stock of our experience.

It is said, and is especially true of the physician, "that no man liveth unto himself." As an educator of the laity, he occupies a commanding position. He is consulted in the greatest confidence upon matters affecting the interest of his clientele, and wields an influence unsurpassed by any, except it may be the minister.

From this point of view, the conviction strengthens, that it is all-important to exercise that wisdom and prudence which co-operation alone will secure in our efforts to perpetuate public favor and friendly legislation. Local societies will naturally gravitate towards and crystalize into a general council.

Furthermore, let us consult together to improve the literary work of our Association. Our contributions should be well conceived, and elaborated after mature thought, and abounding in that scientific and experimental research which will instruct and interest the membership.

It may possibly surprise many of you to know that at our eighteenth annual session, the special committee on Medical Topics assigned eighteen subjects to the so-called Chairman of Committees, and at the succeeding session only four of these made reports. This certainly is disappointing, and may find us in some future session without subject matter for discussion, and leave us dependent entirely upon voluntary productions for our volume of *Transactions*. This is not in keeping with steady progress and advancement. Our work should be well planned for each succeeding session, and some action taken in way of discipline to secure its elaboration, thus affording for each meeting terse, strong and practical papers, and thereby elevate the literary status of our association, and add lustre to the science of medicine in Mississippi.

We come next to notice a subject alluded to by your honored President of last session, viz: The Museum, Library and Laboratory. We believe this is the time to take action looking to this very important work. Having a central and permanent location-every year we defer the matter loses to us valuable contributions which could be gathered up as the fruit of our labor. There are in the offices of many of you, pathological specimens of value, which have their history in the reports of our loved and lamented Hall, and our much honored and faithful Craft. Surgical instruments, appliances and other apparatus have been invented by medical practitioners of our State. The collection of these, with the history of the same, and manner of application, would prove interesting, and could be preserved as valuable relics of the past. Furthermore, we have had from the pen of our venerable and learned fellow, Dr. D. L. Phares, interesting papers upon the medical flora of Mississippi, and it would be a just tribute of respect to his labors and scientific attainments, as well as an honor to ourselves, to collect, under his supervision, specimens of the most important of these, and preserve, them in a laboratory. These are not only valuable to us from a scientific and therapeutic standpoint, but they will serve to show to the world our possibilities in *materia medica*. I could enumerate further quite a number of reasons why we should at once look to the beginning of this work, but deem it only necessary to call your attention to it, trusting that the matter may be discussed freely.

I am aware that we are not possessed of the means to erect such a building as we might desire, yet a committee appointed, having its chairman in Jackson, possibly could secure a temporary structure, and solicit contributions of books, specimens, etc.; meantime looking into the most feasible plan of securing means for the erection of a permanent building. It has been suggested that our sister society, the Mississippi State Pharmaceutical Association, which is now enlisting public sympathy, would become in time, if desired, a valuable coadjutor in this work with us. It might be well if we act now, to confer with them in the proper way, upon the subject.

This enterprise would cluster about it much that is of interest in the progress of medical practice in our State and serve as a sacred repository in which to store up mementoes of our loved, honored and lament brothers whose lives have been sacrificed upon the altar of science and duty. And now, worthy fellows, I close, and in doing so I exhort you to stand shoulder to shoulder in our grand work, indulging every assurance of that success which fidelity to laudable purpose always yields.

The President's Address of 1887, given by N.L. Guice of Natchez, is referred to often by MSMA Presidents in years hereafter. MSMA President Walter W. Crawford of Hattiesburg used this address in his address of 1907 to congratulate the profession "upon its wonderful progress."

in all our annals. On several previous occasions the minutes of meetings record the expulsion of a member for unprofessional conduct, but here is a record of a member being called before the president and by him publicly reprimanded, in open meeting; a remarkable testimony to the loyalty and self-control of the member, especially when we consider how comparatively feeble the Association was at that time. The meeting in Meridian, the following year, **1891**, was without historic interest, the Association pursuing its scientific program and devoting itself to its own internal affairs.

The Association went to Natchez for its **1892** meeting. Acting on the recommendation of President Murry, an effort was made towards the establishment of local societies as nuclei from which an increased membership might be drawn. The secretary presented a list of books in the library of the Association, consisting chiefly of volumes of *Transactions* of other Association's. One of the features of this meeting was a steamboat excursion tendered the members by the citizens of Natchez.

A called meeting was held in Jackson, November 2 of this year, for the purpose of revising the Constitution and Bylaws and to elect members of the Board of Health. A draft of laws had been provided by the president and this, with recommendations and amendments, was laid on the table for action at the regular meeting. Five members of the Board of Health were elected as provided by statute. This is of interest as being the only called meeting on record.

In **1893** the Association returned to Jackson. Action was taken on the revised Constitution and Bylaws introduced at the called meeting in November. In the minutes of this year is found an intimation that the records of the Association were carelessly kept, a committee being appointed to find the missing charter.

The **1894** meeting, held in Jackson, was chiefly of interest from the quantity of scientific work accomplished. There was also a movement started for the establishment of a public bacteriological laboratory.

In **1895** the Association turned its attention to the creation of a Department of Public Health, which was soon afterwards passed upon favorably by the legislature, and took up the question of a Medical Department of the State University. The charter inquired about at the 1893 meeting had evidently failed to materialize, for a committee was appointed to prepare and record one.

The **1896** meeting was held in Vicksburg, where the Association relaxed somewhat in its scientific work and business and indulged in a banquet and steamboat excursion, tendered by the citizens. The question of a Medical Department for the State University was again agitated, the president stating in his address that the legislature had committed itself to such a step.

The Association returned to Jackson for its **1897** meeting. One of the features of business at this session was the establishment of a monthly journal to be published in lieu of the *Transactions* by taking over the *Mississippi Medical Record* which had just been established as a private venture. This plan of publication was continued by the Association for four years, after which the journal was discontinued and the Association returned to its former method of issuing annually a bound volume of *Transactions*.

The **1898** meeting was particularly notable because of the organization of a "Department of Public Health", which was soon established by legislative enactment. This Department had for its object "the collection of vital statistics, the development of medical literature and a general superintendence over the health interests of the state". For several years the report of its chairman was one of the features of the annual meeting of the Medical Association, there being each year a brief mention of it in the *Transactions* until 1904, after which it apparently failed to excite interest among its members or to do any work.

The **1899** meeting was comparatively free from matters of more than scientific interest. The Association took issue with some recent resolutions of the American Medical Association and spent an exciting morning hauling the *Vicksburg Herald* over the coals for wrongly reporting the ideas put forward in one of the papers read before the meeting, but with these exceptions the members attended strictly to scientific business.

In **1900**, once again the Association abandoned the beaten track and went from Jackson for its annual meeting, Meridian being the place selected. Unprecedented floods interfered with the attendance of many of the members, there being only twenty-three who answered the first roll-call and most of these being resident in Meridian. Adjournment was taken for twenty-four hours in the hopes that more would come in but the next day it was decided that the attendance would not justify a continuance so an adjournment was taken for a month, the meeting being held in May, when the Association reconvened in the same city and held an interesting session. The legislature was petitioned to provide quarters for the Board of Health in the new capitol building and the Board was endorsed in its actions during the epidemic of the previous year. An excursion to Arundel Springs was enjoyed by the members.

The Association returned to Jackson in **1901** where the theory of transmission of yellow fever and malaria by the mosquito had the floor in a most interesting discussion. Drs. Hunter and Gant of Jackson presented a paper on "Contagious And Infectious Diseases" that was ordered printed for distribution among the members of the legislature and a committee was appointed to present the facts contained therein to them at the next session.

At the **1902** meeting the executive committee presented for the consideration of the Association the laws relating to county health officers and coroners, urging that the salaries and duties of the former should be equalized by legislative enactment and that steps be taken to see that the latter be always chosen from among the members of the medical profession. These recommendations were referred to the committee on legislation with the endorsement of the Association but nothing was accomplished.

The **1903** meeting marks the beginning of an increased interest in organization on the part of the physicians of Mississippi. This meeting was to have been held in Greenville but, owing to prolonged overflows in the Delta that made traveling by rail uncertain, the committee in charge found it advisable to transfer the place of meeting to Vicksburg.

Dr. McCormack, organizer of the American Medical Association, was in attendance at the invitation of President Sutherland and addressed the Association, advocating reorganization on the lines suggested by the AMA committee. A committee spent two days considering the plan and recommended its adoption, which recommendation was adopted by a unanimous vote. The wisdom of this move was apparent, as is manifested by the report of the secretary at the **1904** meeting: "We have, through our councilors, effected organization in forty-six counties, with a total membership of five hundred and twenty. Of them, one hundred and forty-two were already members, leaving a net gain since our last meeting of three hundred and seventy-eight members; the largest gain by far for any year in our history".

At this meeting the Association decided to resume relations with a monthly publication and adopted as its official organ the *Journal of the Mississippi State Medical Association,* published in Vicksburg, the name of which was changed in 1906 to the *Mississippi Medical Monthly.* The Association also took steps to perpetuate the records of the Surgeons of the Confederate States from Mississippi by appointing Drs. J. C. Hall, J. A. Rowan and H. Christmas to a committee to take the matter up with and to assist the Department of Archives and History of Mississippi.

There is little of interest to be noted in the year prior to the **1905** meeting. The officers apparently rested on their oars and were satisfied with the results of the previous twelve months and the natural gain in membership that would necessarily accrue from them, for the minutes of the meeting, which was held in Jackson, show nothing of work or progress beyond the introduction of a resolution requesting the county societies to bestir themselves in an endeavor to secure from the legislature an appropriation for a state bacteriological laboratory.

During the year prior to the **1906** meeting the work of the Association was severely handicapped by the prolonged illness of its secretary but this was in a great degree compensated by the energy of the president. Dr. E. H. Martin of Clarksdale, who personally conducted a campaign for increase of membership and succeeded so well that the meeting in Jackson over which he presided was by far the best, both in attendance and in work accomplished, that had yet been held. The secretary's report shows an increase in membership of one hundred and thirty-eight with five organized counties not reporting, and an increase of seven in the number of organized counties. At this meeting the Association contributed one hundred dollars to the N. S. Davis Memorial.

One of the most interesting items in the minutes of this meeting is the following resolution: "Resolved, that the gratitude of this Association has been earned by Dr. C. Kendrick and other physicians of our State Legislature for their indefatigable and earnest labors for the protection of the public health and the interest of regular medicine in Mississippi".

The **1907** meeting, held at Gulfport, was notable for the launching of an organized movement for the upholding of fees for insurance examinations and the passage of resolutions requesting the legislature to require a diploma as a requisite for application for examination for license.

The question of the insurance fees was one that had excited much interest for the year prior to the meeting, Adams County being the hottest storm-center, and a number of the county societies had already taken action in the matter. The Association did not make adherence to the resolutions passed by the House of Delegates, on this occasion a test of membership and therefore there was some falling off, but much good was accomplished by them.

The resolutions are as follows:

"Whereas, the class of examinations required by life insurance companies is of a nature which entails responsibility and which in justice to the medical profession should not be made for less than $5.00; and

"Whereas, we charge a similar fee for examinations of a like character; therefore be it

"Resolved, that we, the members of the State Medical Association, hereby agree to make no examinations for any old-line life insurance company for a minimum fee of less than $5.00; and

"Resolved further, that the officers of all county societies request, and if possible obtain, from all reputable physicians who are not members of our Association, an agreement to cooperate with the local societies in maintaining the $5.00 fee for such examinations.

"Resolved further, that no member of this Association enter into any compact or agreement with any corporation, society, Association, company or individual to examine applicants for insurance for any stated salary or lump sum, thereby evading the spirit and intent of these resolutions.

"Resolved further, that the payment of all fees shall be authorized by the home office of the society or corporation to which such application is made, and under no circumstances shall an examiner receive or accept any part of a fee from an agent or other person unless the full fee be paid by authority of the home office.

"Resolved further, that each member of this Association pledge himself or herself that in case a fellow-member be removed from the position of examiner for any corporation or society solely because of this action of the Association, that he or she will not accept the appointment from such corporation or society as examiner, or make any examinations for the same in Mississippi.

"And Be It Further Resolved, that these resolutions go into effect on and after their passage."

The following year, **1908**, the Association went to Natchez, where it was given a royal welcome. The financial stringency of 1907 had caused a slight falling off in membership and the inaccessibility of the place of meeting reduced the attendance very materially, but those who were present were amply repaid for extra exertions by the social attentions, which exceeded anything in the recent history of the Association.

Dr. J. N. McCormack of Bowling Green, Ky., the national organizer of the American Medical Association, was the guest of honor on this occasion and entertained and delighted the members with an address replete with humor, eloquence and good advice.

Dr. W. H. Aikman, on behalf of the Adams County Medical Society, presented the Association with a gavel "composed of five pieces of wood held together by bands of silver; the bands at the ends being expanded to extend over the different pieces and on these expanded surfaces at one end is engraved the names of the places where the wood was grown or whence it came. At the other end, on the corresponding surfaces, are recorded events, names and dates that make these five places notable in local history. Beginning at the handle we have a piece of red cedar from Windy-Hill Manor, where that adventurous character of American History, Aaron Burr, was concealed in 1807. Next, a piece of white cedar from a large tree that grew on The Briars, where Jefferson Davis was married February 26, 1845. Then a section of poplar from Longwood, where Sargeant S. Prentiss was married on March 2nd, 1842, and where he died July 1, 1850. Next a piece of walnut from Concord, where stood the residence of the last Spanish governor, Gayoso, this residence being built in 1789. The piece of hickory and the hickory handle grew on Monmouth, the home of Gen. Jno.A. Quitman, a hero of the Mexican war and military governor of the City of Mexico, being made governor by General Scott in recognition of his valor in being the first to have his troops within that ancient citadel".

In **1909** the annual meeting was held in Jackson under the presidency of Dr. J. W. Gray of Clarksdale. The Association this year, for the first time, passed the one-thousand mark in membership, and the attendance at



In 1908 Dr. W. H. Aikman, on behalf of the Adams County Medical Society, presented the Association with a gavel made of five types of wood: red cedar from Windy-Hill Manor, white cedar from The Briars, poplar from Longwood, walnut from Concord and hickory from Monmouth. See photos next page.



Close-up photos of the gavel presented to MSMA in 1806 by the Adams County Medical Society. The mallot end is composed of five pieces of wood held together by bands of silver; the bands at the ends being expanded to extend over the different pieces and on these expanded surfaces at one end is engraved the names of the places where the wood was grown or whence it came. At the other end, on the corresponding surfaces, are recorded events, names and dates that make these five places notable in local history. Beginning at the handle we have a piece of red cedar from Windy-Hill Manor, where that adventurous character of American History, Aaron Burr, was concealed in 1807. Next, a piece of white cedar from a large tree that grew on The Briars, where Jefferson Davis was married February 26, 1845. Then a section of poplar from Longwood, where Sargeant S. Prentiss lived. Next a piece of walnut from Concord, the residence of the last Spanish governor, Gayoso. The piece of hickory and the hickory handle grew on Monmouth, the home of Gen. Jno.A. Quitman, a hero of the Mexican war and military governor of the City of Mexico.



1907 PRESIDENT'S ADDRESS

WALTER W. CRAWFORD M.D., HATTIESBURG

Gentlemen of the Mississippi State Medical Association:

Instead of giving a dissertation on some abstract theme this evening, I wish to discuss some questions that are of special importance to the profession of our state today.

There has never been a time in the history of medicine when systematic and comprehensive endeavor has so thoroughly characterized its every department. We are no longer content with the methods and measures of our fore-fathers, but from every quarter of the globe Champollions are appearing with interpretations for the Rosetta Stones of science that have so long been in the helpless grasp of the profession. With our research laboratories to supplement bedside and therapeutic observation, we are rapidly becoming in rapport with the demands of our calling.

It is my privilege to have recently read the annual address of one of my predecessors delivered before this association twenty years ago. . In it he congratulated the profession upon its wonderful progress, and did it justly. In my imagination I picture this same gentleman, who is still an active practitioner and has kept in touch with modern advancement, writing another address. He has a resume of medical achievement from the time when Hippocrates crossed to the Stygian shores down to the opsonic index of the present. He would recall that the first deliberate operation for appendicitis was chronicled the same year that first address was written; that all the work now being accomplished with safety and precision on the stomach, gallbladder and pelvic contents, has found a definite abiding place in our science since then. He sees the nervous individual with rapid heart, disfigured neck and prominent eyeballs brought again into normal relations with life; severed nerves repaired with complete restoration of function; anastomoses of cutblood vessels. He sees that the ambitious surgeon has even transferred the kidney from its normal resting place to the neck and bade it continue to perform its function. He observes that man no longer depends upon the puny light of the sun, the sense of touch or logical deduction to determine whether or not there has been a solution in continuity of bone or whether a foreign body has found lodgment in a given locality, but, utilizing the principle that the good and useful are often obscured by intimate association with opposing influences, he has learned to analyze light and bring into activity the x-ray, with its powers to penetrate and to heal. The progress of these twenty years has made it possible for him to approach the bedside of the erstwhile hopeless little victim of laryngeal diphtheria with perfect confidence because of the definiteness of antitoxin. He observes the practical application of this discovery in that other sera have been and are being evolved for a variety of diseases.

Paraphrasing the words of Napoleon when with his army he viewed the pyramids of Egypt: twenty centuries of medicine look down upon us; but the rapidity with which the science has responded to our research during recent years warrants the presumption that during all these centuries we have had to do with an embryo, and that the soil and moisture of circumstance have just begun to develop its latent possibilities, and we may reasonably expect that a convergence of the forces that are now in active existence will unfold a plant whose branches will provide a panacea for all the ills incident to germ life.

While the achievements of the past two decades have been far-reaching and warrant the most extravagant speculation for the future, yet they have not begun to comprehend all of the demands of the great art of healing nor the possibilities of medical science. There are numerous diseases whose treatment is most unsatisfactory to both patient and physician. This has been notably true in regard to tuberculoses, a disease that is as old as man, a disease that has left more tombstones to stand in silent mockery of man's failure to arrest its progress than a combination of all the other infectious diseases that engage the American physician.

Both the profession and general public are becoming impressed with the importance of this subject and in many sections are waging a campaign of education. This is well, but the doctor, whose knowledge of sanitary prophylaxis warrants intelligent leadership, should not only plan the battles but should be on the firing line.

The plan of organization adopted by the American Medical Association a few years ago, comprehending as it does the various states and their component county societies, comprises a most attractive as well as practical system, and yet a system that in its present degree of organization does not meet all the demands of the medical profession. It is pleasing to come together in the monthly county meetings and in addition to the scientific programme to discuss the varied topics of local character with one's fellows. The annual state meetings are welcomed for the same reason. The national gatherings, while largely attended, attract very few from the individual state. This is due primarily to the fact that in a country so large as ours, even the most central meetings are far removed from the outlying states; thus depriving many of those from attendance whose practice limits their absence from home. Even with these limitations the national body has attained such proportions as to deprive a large percentage of those who do attend its sessions from participating in its programme.

In anticipation of this state of affairs the American Medical Association provided that district organizations might be formed from states whose geographical relationship and tastes would suggest such an arrangement. In accordance with this idea, delegates from Louisiana, Mississippi, Alabama, Tennessee, Georgia and Florida met in Chattanooga, October 4th 1906, and acting with the tri-state society of Tennessee, Alabama and Georgia, then in session, formed the southern branch of the American Medical Association, an organization with no legislative department but whose sole function is to be scientific work. Being in direct affiliation with and endorsed by the American Medical Association, it at once commends itself to the profession. Every member of its component state societies is eligible to its membership. Such a society should, and we believe will, add to its roster a large membership of the best men in the south, We heartily commend it to you.

Mississippi has for many years taken a pardonable pride in her efforts along educational lines. She has ranked ahead of the other southern states in establishing and maintaining an industrial institute and college of high order for girls, and has pursued a

liberal policy toward almost every institution calculated to elevate and enlighten her citizenship. For many years she has, through her State Board of Health, required applicants for license to practice medicine, to pass a rigid examination. This has had a most wholesome influence, in that it has not only stimulated higher attainment on the part of the student who expected to practice medicine within her borders, but has impressed medical colleges in this territory with the importance of a higher curriculum and more exact teaching. At a glance such a situation would seem ideal. But, you will inquire, what are the requirements to gain permission to go before the Board of Health for these examinations. None whatever, and this is the weak and yet the most important link in the whole system. The country has numerous well-equipped colleges and hospitals whose only excuse for existence is to provide students with the necessary information for a work in which human life is taken daily to task, and need I say a work whose responsibilities should inspire the most thorough preparation on the part of those who elect to do it; and yet a man who has never seen a medical college or hospital is accorded the same right to take the examination and receive a license as the man who has given-many years serious preparation in our best institutions. That this should not be needs no argument. However, the matter cannot be changed by the State Board of Health but, if corrected at all, must be done by legislative enactment. There are only eleven states in the union that do not require applicants for license to present their diplomas before the examining board. That our state belongs to that number we regret. The individual voter has entrusted his family to our guidance in matters of health. He has even been willing for us to administer to the indigent sick of the community without hope of recompense, but through the constituted authorities of the state, who are to conform to his wishes, he has not only refused to offer us any protection in the collection of those accounts made by patients who have the capacity but not the inclination to pay, but be has thus far refused to help us to protect him against the imposition of a class of men who are gaining entrance into our profession with no technical qualifications for the practice, men who know nothing of that sublimity of thought that comes as an earnest for a duty well performed, but men to whom patients are welcome because they provide a means for the acquisition of material wealth. I refuse to believe that our citizenship will continue to tolerate such an inconsistency, and I wish to enter a plea here and now that every member of this association ask his representative and senator to see to it that in the 1908 session of the legislature our state shall declare that none but graduates shall have her seal of approval for the practice of medicine.

I deem it my duty gentlemen to call your attention to the status of the contest between the doctors and the Life Insurance Companies. We will recall that at our last annual meeting a resolution was adopted requesting all county societies to refuse to make old-line examinations for less than the original fee of five dollars. In accordance with that resolution the matter has been properly presented and discussed by most of the societies. Some promptly adopted, others kept the matter under consideration for a time in order to secure more harmonious support, while a third class has waited for the present meeting for more emphatic instruction. More than thirty counties have given it unconditional support, and from the sentiment throughout the state we confidently believe that all of the organized counties will have done so in less than six months. The capable and conscientious examiner is the greatest safeguard known to life insurance. Without the proper administration of this department, both policy-holder and stock-holder must have their interests jeopardized. That the examiner has given faithful and intelligent service during all of the past, the multiplied millions of surplus attest. Should the representative men in the profession continue to make these examinations, even though they made them free, they would give the same high-class service as heretofore because they are men of integrity. The insurance companies know this and have hoped to have an additional two dollars from each applicant to apply to fabulous salaries and other sources of expenditure foreign to the interests of the policy-holder, by withholding them from the doctors who have carefully passed on the risks. They have miscalculated however, and are reaping a whirlwind, because there is a principle involved greater than the sordid fees, and the profession over the entire country is declaring against such injustice. 'Tis true that here-and-there are men of some prominence in the profession who, for private hope or personal gain, may insist that after all we are amply compensated and should not be so presumptuous as to object to having the insurance companies totally disregard the proper estimate of our services. But I congratulate the profession that such men constitute an insignificant minority and even they will count the cost and decide to live in harmony with a profession, the beauty of whose ethics bar; ever been a source of admiration from the world.

In an interview with the president of the American Medical Association a few months ago I was assured that, from the most healthful optimism in various portions of the country, there would undoubtedly come a complete triumph for us. I agree with the doctor, but would have you remember that you are to contribute toward such an end.

In conclusion, gentlemen, it is your duty to name five members of the State Board of Health at this meeting. This is a most important concession, provided by our statutes, and while that number constitutes a minority of the Board, let us see to it that it consists of men who thoroughly represent the best interests of both profession and laity. Men who not only possess the intellectual force and moral stamina to represent us, but who have been loyal to the Association and have contributed towards the success of its scientific work. In this connection allow me to say that much of the efficiency of the State Board, in its final analysis, finds expression in the work of the county health officers. In fact, the county health officer is at once the sentinel and executive officer in his own territory. Ever alert, he is ready to locate infectious diseases and suppress them before there has been a general exposure of the community. His is the real danger, and yet the value of such services is totally disregarded in most counties as evidenced by the fact that some pay fifty dollars per year while others pay fifteen hundred dollars. There should be uniformity of salary. The boards of supervisors have the power to arrange the matter, but have not done so.

Last summer a state convention of boards of supervisors was held in my city. Appreciating the fact that it was an opportune time, I requested the health officers in the counties nearest Hattiesburg to help the member of the State Board of that district and myself to present the subject of salaries before the convention. This was done and we believe was productive of some good. We further believe that if the matter is again brought before that body at its Jackson convention during the coming summer, it will result in the equitable adjustment of the question.



This photo (circa 1907) taken in front of Hardy Funeral Home on the corner of South President and Pascagoula Street in downtown Jackson, of an invalid carriage shows how the horsedrawn carriage served as hearse and ambulance. Photos (above and below) printed with permission, MS Dept. of Archives & History.



Mississippi State Charity Hospital Ambulance, Circa 1915.

the meeting was greater than ever before.

The delegates, after a heated discussion of the insurance-rate war, added the following to the Gulfport resolutions: "Resolved that the Association reaffirms the Gulfport resolutions, and that it is the sense of the Association that the acceptance by any member of any insurance-examination fee of less than five dollars is a tacit admission on his part of professional inferiority to his fellow members who demand the five dollar fee."

A matter of no small satisfaction was the opportunity to show appreciation of one of the martyrs to medical science. The organized profession of the country was raising a fund to purchase a home for the widow of Dr. Jas. Carroll, whose death was directly attributable to an attack of yellow fever contracted voluntarily in the effort to demonstrate the transmission of the disease by mosquitoes. The Association appropriated one hundred and fifty dollars for this purpose, to which the individual members present at the meeting contributed an equal amount.

This year, for the first time, the Association seemed to wake to the full realization of the necessity of doing more than merely memorializing the legislature as to the need for medical legislation and appropriated five hundred dollars to be used by the committee in necessary lobbying. Dr. D. W. Jones, installed as president at the **1909** meeting, selected his committee on public policy and legislation with care, making Dr. P. W. Rowland of Oxford its chairman. This committee held several meetings in the autumn of 1909 and the winter of 1909-1910, and presented to the legislature that convened in January 1910 several bills calculated to better medical affairs in the state. Their fate is best told by Dr. Rowland's report to the House of Delegates at the **1910** meeting in which he condemned, in no stinted terms, the apathy of the legislators and the obstructions cast in the way of the committee by some of the members of the Association. He concluded his report by offering the following resolution, which was adopted by the House:

"Whereas, the Mississippi State Medical Association at its last meeting appointed a Committee on Public Policy and Legislation for the purpose of the Legislature, of several urging the passage, by measurer, of great importance to the profession and to the people of the State, and

"Whereas, this committee, on account of the apathy and indifference of the members of the legislature, and on account of the active opposition of members of this Association, failed to secure the desired legislation; therefore be it

"Resolved, that we do heartily and earnestly condemn the attitude of the members of the Legislature towards this Association in their utter lack of appreciation of the efforts to improve the health conditions of the same, and to place upon a high plane of efficiency and usefulness to the general public the members of the medical profession.

"Resolved that we do reiterate our former action in placing ourselves on record as demanding a diploma from a reputable medical school as a prerequisite to the obtaining of license to practice, and in addition thereto that the practice act should be so amended as to require that all persons who desire to obtain license to practice medicine in the State of Mississippi must apply therefor in writing to the State Board of Health and must present a diploma from a reputable school of medicine whose course of study shall consist of not less than four years of not less than thirty weeks' work, and whose requirements for entrance shall be that of a diploma from a Mississippi high school or its equivalent."

At this meeting steps were taken looking towards a legal defense department as an adjunct to the Association, which would also be provided with powers and funds to push legislative matters.

This was also the year the AMA released the Flexner Report, *Medical Education in the United States and Canada,* and the AMA Council on Medical Education published its first edition of *Essentials of an Acceptable Medical College.* The Flexner Report, funded by the Carnegie Foundation and supported by the AMA facilitated new standards for medical schools and cited many diploma mills. The results of the report meant the demise of many inferior and unacceptable medical schools including the Mississippi Medical College in Meridian, which opened in 1906.

"Of the two (Mississippi) schools, that at Meridian is without merit," the Report cites. "At a time when the state already has more doctors than it needs, the starting of a didactic school, conducted by the practioners of a small town, is absolutely unjustifiable. The state laws ought to be promptly amended so as to make such ventures impossible," the Report said.

It went on to say of the Medical College, "At the date of visit, it did not own a dollar's worth of laboratory apparatus of any description whatsoever. A questionably reliable report credits the school with what amounts to simple elementary chemistry sets and twenty brand new microscopes, but not matter to use with them. Of clinical facilities there are practically none. Some of the faculty have places on the staff of a small hospital, Matty Hersee, over a mile distant. There is no dispensary."

Neither the Council on Medical Education or the Carnegie Foundation had any legal powers and the clo-

sure of the Mississippi Medical College in 1912 was largely due to the staunch support of the Mississippi Licensing Board.

"There was still one graduate of the Mississippi Medical College practicing in the State when I entered medical practice in 1957."

-Dr. Vann Craig
MSMA President-Elect
Natchez Surgeon



Anatomy laboratory in the Mississippi Medical College, Meridian.



The Mississippi Medical College, 2402 Fifth St. This building was used until the Avery Mansion was purchased.



The Matty Hersee Hospital, organized in 1892 and erected in 1903.

This defeat, however, served to stimulate the Association to greater efforts in **1911**. Dr. H. L. Sutherland of Rosedale initiated the attack with a paper on "The Duty of the State In The Conservation of Human Life And Energy" which was presented at the annual session and given to the public press.

The various matters in which the Association had met defeat in the legislature were reintroduced and energetically pressed and the following year the **1912** Legislative Committee was able to report complete success with every measure introduced. The appropriation for the State Board of Health was increased from eight to twenty-five thousand dollars, a Bureau of Vital Statistics was created, and a law was passed providing that only graduates of recognized medical schools might apply for license to practice.

The following year, **1913**, we find the Association preparing to honor a former member who, since leaving Mississippi, had been successful in throwing additional light on a problem peculiarly interesting to the South. Dr. C. C. Bass' recent studies of the malarial parasite and his application of the information thus acquired in the control of the disease had added materially to our knowledge and in recognition of his services the Association voted him a medal, which was presented at a 1914 meeting by Dr. J. S. Ullman.

At the forty-seventh annual session in **1914** efforts were made to abandon the Insurance Resolutions passed in 1907.

An interesting bit of attempted discipline was shown in the introduction of a motion declaring vacant the office of Councilor in those districts for failure in the performance of duty.

A well-deserved tribute was paid the Association's best, beloved member by electing Dr. H. L. Sutherland of Rosedale an honorary member, the first to be so honored.

The **1915** annual session, held in Hattiesburg, is chiefly of note in that there was first agitated the question of a state hospital for tubercular patients. A general committee was appointed to present the matter to the legislature and given full authority to invoke the support of the Association, through the county societies.

An interesting example of the power of organized medicine is shown in the report of the Council. The Secretary of the Southern Medical Association had been extremely lax in the matter of requirements for membership in that body, accepting Mississippi physicians who were not members of the State Association. Complaint having been filed, the Southern's secretary admitted jurisdiction of the State Council and, proof having been made, agreed to comply with regulations in future.

The chief attraction of this meeting, was the presence of Dr. Rudolph Matas of New Orleans who appeared before the surgical section and also delivered the Oration, choosing as his subject one on which he was eminently qualified to speak: "The Soul of the Surgeon."

By far the most important and most interesting matter before the Association at its **1916** meeting is described in the report of the committee on Public Policy and Legislation. By direction of the House, this committee had sponsored Bills for the prevention of ophthalmia neonatorum and to establish and maintain a Sanatorium for the care of incipient tuberculosis. The former passed the Legislature "almost unanimously", the latter with only eleven dissenting votes. Here we find one of the few instances of the Association conferring a special honor on one of its members.

A loving cup was presented Dr. Carroll Kendrick of Alcorn County in recognition of his long and faithful service to the profession and the people of the State; twenty-six years in the State Senate, during which time his constant and able championship of public health affairs and his loyal activities in behalf of his profession made for him an enviable record.

As was the case with most meetings held during **1917**, the annual session, which was held in Jackson, resolved itself to a considerable degree into a war meeting. There were only twenty Mississippians in the Medical Reserve Corps and the state quota was one hundred and seventy-five. An examination bureau was established in a place convenient to the meeting hall and the meeting itself, the afternoon of the second day, turned into a recruiting station. The results were quite satisfactory. The records show that three hundred and ninety-two Mississippi doctors served in the Army and seventeen in the Navy. Of these, two hundred and seventeen soldiers and five sailors were members of the Association.

The **1918** session, showed the reflection of the war very considerably. Paid membership to May 1 had dropped to seven hundred and ninety-six, partly due to the heavy loss by enlistment, part to the fact that many of the county secretaries had joined the colors. An amendment to the Bylaws was passed remitting the dues of all members in service in the army and navy. The Transactions of this year does not carry a record of the registration at the meeting, but the fact that it contains only a dozen scientific papers, and three of these by non-residents, shows rather conclusively that the Mississippi profession gave of its best to the service.

Hattiesburg was the scene of the **1919** session, the second day's meetings being held in the Base Hospital at Camp Shelby. More than two hundred and fifty members



Scenes from the Mississippi State Charity Hospital, 1915. Photos printed with permission, MS Dept. Archives & History.



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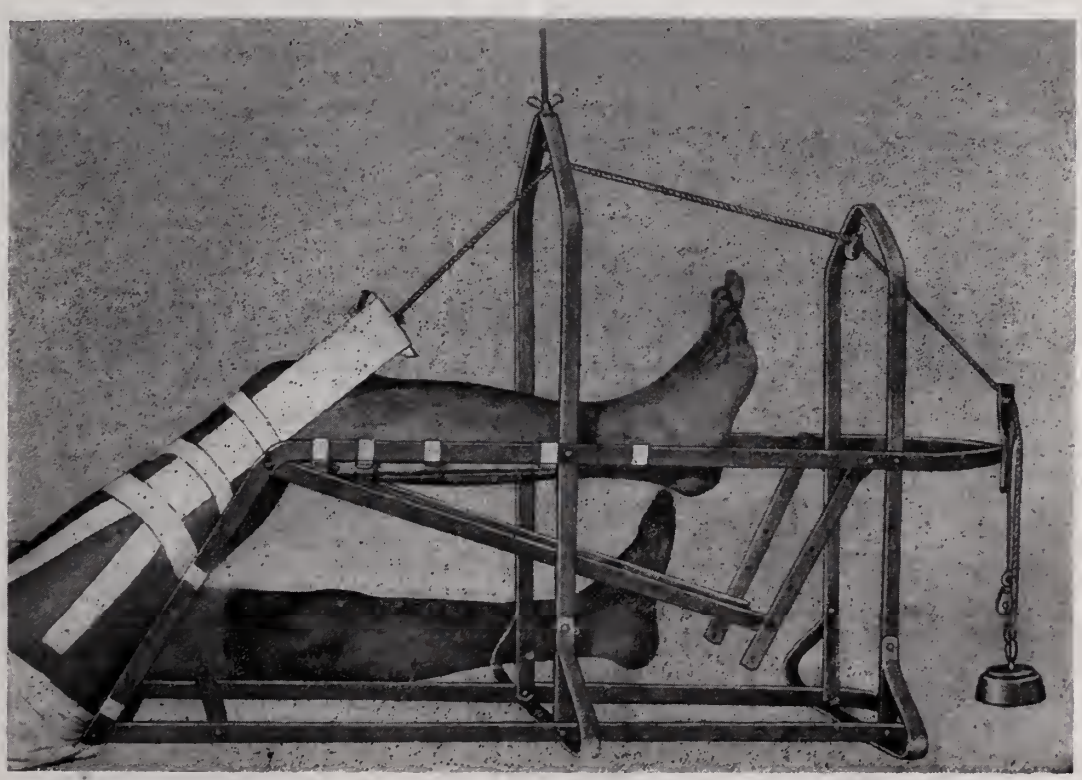
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2.—The hospital has a modern ambulance, well equipped for comfort and safety. Transportation of the sick for a long distance is very dangerous. This danger is greatly reduced by the use of our Ambulance, over the best system of roads in the state. Saving time often saves lives. The rates are reasonable.

3.—The nurses are kind, courteous, gentle and efficient. They are selected from the substantial Christian homes of our community. The best citizens of Tupelo will endorse their conduct.

4.—The local churches have helped our hospital by furnishing elegantly several rooms and the pastors of these churches make visits almost daily to its wards.

5.—There is a well equipped x-ray department in charge of a specialist. An electric elevator, a costly modern operating table and a machine for giving gas anesthetics, have recently been put into service, and many other improvements have been made during the past year.

6.—The hospital has a staff of efficient physicians, surgeons, and eye, ear, nose and throat specialists.

For any other information about the hospital ask your own family physician who can give you competent and dependable advice about this institution.

When in Tupelo, visit the hospital.

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(Approved by the American College of Surgeons.)

ANNUAL REPORT
OF
HOUSTON HOSPITAL
OF HOUSTON, MISSISSIPPI
JANUARY 1, 1922. TO JANUARY 1, 1923

Our sole method of advertising is through the physicians and the results we may obtain in the care of patients whom they are courteous enough to refer to us. It is through their kindness that our annual report continues to grow and we are most grateful to them for their liberal patronage.

REPORT

Number	OPERATIONS	DISEASE	Results: Recoveries	Results: Improved	DEATHS
176	Appendectomies	Appendicitis	171		5
2	Amputation of hand	Necrosis of Bone	2		
1	Amputation of foot	Necrosis of Bone	1		
1	Amputation of foot	Gangrene	1		
1	Amputation of left leg	Contusion	1		
1	Amputation of right leg	Osteo-sarcoma of knee joint	1		
1	Amputation of right leg	Gun shot wound followed by Gangrene			1
1	Addenectomy	Tubercular addenitis of throat gland		1	
1	Addenectomy	Suppurative addenitis of left inguinal gland	1		
1	Arthrotomy	Arthritis of left ankle	1		
8	Cholecystostomies	Gall stones or infected gall bladder.	8		
5	Cholecystectomies	Gall stones or infected gall bladder.	5		
1	Circumcision	Elongated prepuse	1		
2	Circumscisions	Adhesions of prepuse	2		
1	*Cautery	Carcinoma of uterus			
5	Currettages	Endometritis	5		
5	Currettages	Abortions	5		
1	Currettement	Peri-Rectal abscess	1		
1	Currettement	Ulcer of leg	1		
3	Casts	Tuberculosis of spine			3
1	Cast	Arthritis of right knee	1		
1	Cast	Suppurative sinusitis of left knee	1		
1	Cast	Curvature of the spine		1	
1	Drainage	Abscess of chest		1	
12	Deliveries	Pregnancy	12		
1	Dressing	Gun shot wound of shoulder	1		
1	Dressing	Gun shot wound of chest	1		
1	Dressing	Gun shot wound of abdomen			1
1	Dressing	Gun shot wound of fore arm	1		
1	Dressing	Contusion of back and neck	1		
1	*Exploratory Lap	Sarcoma of Mesentary			

(Continued on Page 6)

ANNUAL REPORT OF HOUSTON HOSPITAL
(Continued from Page 5)

1	Exploratory Lap	Gun shot wound of abdomen		1
1	Extraction	Cataract	1	
3	Foreign bodies removed	Foreign bodies in ear	3	
4	Foreign bodies removed	Foreign bodies in nose	4	
4	Foreign bodies removed	Foreign bodies in eye	4	
2	Forced Deliveries	Pernicious vomiting of pregnancy	2	
1	Fixation & Cast	Fractured tibia	1	
1	Fixation & Cast	Colle's fracture	1	
5	Fixation & Cast	Fracture of neck of femur	3	2
2	Fixation & Cast	Compound fracture of femur	2	
1	Fixation & Cast	Fracture of left tibia and fibula	1	
43	Hysterectomies	Fibroid uterus	43	
1	Hysterectomy	Ectopic pregnancy	1	
10	Herniotomies	Hernia	9	1
7	Hemorrhoidectomies	Hemorrhoids	7	
1	Incision, external	Laryngeal abscess		1
1	Incision of	Abscess of chest	1	
1	Incision of	Abscess of right leg	1	
1	Incision of	Abscess of cornea		1
1	Incision of	Abscess of right scrotum	1	
2	Incisions of	Peritonsilar abscess	2	
1	Incision of	Gangrene of perineum		1
3	Incisions of	Anal fistula	2	
1	Incision of	Palmer abscess	1	
1	Incision of	Cellulitis of hand	1	
1	Incision of	Alveola abscess	1	
1	Iridotomy	Tromatic Perforation of cornea	1	
4	Laporotomies	Adhesions	4	
1	Laporotomy	Abdominal pregnancy (six months)		1
1	Laporotomy	Intestinal obstruction	1	
1	Mastoid	Mastoiditis	1	
1	Myomectomy	Pedunculated fibroid	1	
2	Ostomies	Osteomyelitis	2	1
1	Removal of	Septal spur	1	
1	Removal of	Urethal caruncle	1	
3	Removals of	Nasal polypus	3	
4	Removals of	Lipoma	4	
2	Removals of	Lymphangioma'a	2	
2	Replaced bones & sutured	Fractured nasal bones	2	
1	Radical Nasol Antrum	Chronic sinusitis	1	
3	Radical breast amputations	Carsinoma of breast	3	
18	Suspensions of the uterus	Retroversion of uterus	18	
1	Sutured	Lacerated eyelid	1	
1	Sub mucous resection	Nasal septum	1	
30	Tonsilectomies & Adenoidectomies	Adenoids & diseased tonsils	30	
18	Tonsilectomies	Diseased tonsils	18	
57	Tubo ovarian operations	Diseases of tubes & overies	57	
1	Trephine	Gun shot wound of head	1	
1	Trephine	Fractured Frontal bone	1	
3	Thoracostomies	Empyema	3	
1	Thoracostomy	Pleural abscess	1	
1	Thoracostomy	Carcinoma of left lung		1
6	Thyroidectomies	Goiter	6	
2	Turbinectomies	Chronic frontal sinusitis	2	
1	Tapping	Overain cyst	1	

*No Benefits

Total number of Operations, 509
Total number of Recoveries, 484
Total number improved, 11
Total number of Deaths, 12
Total number not Benefited, 2.

(Continued on Page 7)

were in attendance, a good average for such a location, and happy indeed were the greetings between men not yet quite accustomed to the fit of civilian clothing, where here-and-there some man in olive drab, who had not yet secured his release, was a center of interest and sympathy. The Association presented itself with a service flag which was unfurled by Dr. C. D. Mitchell of Jackson, and a response was made on behalf of the service men by Dr. W. W. Crawford of Hattiesburg.

The records of **1920** show little of interest beyond public health matters. The tide of liberality on the part of the Legislature had continued, so that the Legislative Committee was able to report nearly a million and a half dollars for permanent improvements at the Tuberculosis Sanatorium and a large increase in the appropriation for its support; and an increase from ninety-five to three hundred thousand dollars, for the two year period, in the appropriation for the Board of Health. The Executive Officer of the Board acknowledged the obligation in these words: "The splendid results which have been achieved in medical legislation for the last ten years have been made possible through the cooperation and loyal support of the medical profession."

This success seems to have satisfied the Association's appetite for accomplishment, or perhaps the efforts required exhausted its **1921** energy, for we find singularly little of interest in the records of the next three years. So much is this the case that the Secretary's report in **1922** is limited to the simple statement: "The best possible report that I could make to you is there is nothing to report;" a statement that, while apparently entirely accurate, reflects very little credit on the organization. It may be, however, that this was a period of incubation of an idea that showed its first symptoms in **1923**, when a committee of five was appointed to consider the proposition of joining the Louisiana State Medical Society in the purchase of the *New Orleans Medical & Surgical Journal*. This Committee was given full power to act for the Association but apparently did nothing, at least there are no records to show that it acted in any way, but the idea was evidently not entirely unpleasing to the members, for the following year, **1924**, when the Louisiana Society, which in the meantime had purchased the Journal, invited the Mississippi Association to abandon the *Transactions* and adopt the Journal as its official organ, another committee with like power promptly accepted the invitation.

Legislation looking to the protection of young children from burns by lye and similar commodities of common use in homes was suggested at the 1925 meeting by the American Medical Association, which was endeavoring to obtain national and state laws governing the matter, and a bill to this end was introduced at the 1926 session of the Legislature; but the Committee became involved in a fight with Chiropractors, who were seeking the establishment of a Board of Examiners of their own, and the bill was pigeonholed. It was not until 1930, when it was introduced by Senator Culkin of Warren County as a personal measure, entirely separate from Association affairs, that it became a law.

Vicksburg was to have been the scene of the **1927**

Notice

John L. Ware, Manager of the Edwards Hotel placed an ad in the MISSISSIPPI DOCTOR last year. The flood came and run the meeting of the State Association back to Jackson to the Edwards Hotel. Mr. Ware has renewed his advertisement and no telling what will happen to Meridian next May if their leading hotel does not get an ad in the Journal.

Reprinted from the MISSISSIPPI DOCTOR-
Volume 5, Number 3, September 1927

oOo

North East MS Medical Society

All ye who can swim, don't forget your bathing suits when you start to Aberdeen for the North East Mississippi Medical Society meeting. It goes without saying that Aberdeen has one of the finest, cleanliest, up-to-date, artificial swimming pools in the state or in the south.

Those of you who were in Amory will agree the town did itself proud as usual on entertainment. The high water kept many away so the crowd was small, but even so it was an extra good meeting. Everyone enjoyed the oil well exuberances that was added to the already accustomed good fellowship. The banquet was a royal feast, served in elegant style, and sauced with literary productions of home talent in high order. Amory is a town of more than usual innate Southern culture and refinement; but unlike some others it is not stiff and stale with Southern Ancestry. It was already in step with the general progress and prosperity of the South and especially Mississippi. It is an interesting town in which to spend a day attending a medical meeting or just "setten" around the "main hotel" which would be a credit to any town in Mississippi.

Reprinted from THE MISSISSIPPI DOCTOR,
Volume 4, Number 11, April 1927.

oOo

meeting, but the disastrous floods in the Delta had so filled the city with refugees that accommodations were taxed to capacity and the members who lived there had their hands full of other business than that of entertainment, so the meeting was transferred to Jackson. The disaster that had necessitated the change was not, however, passed unnoticed by the Association. One thousand dollars were given to the Auxiliary to purchase materials for making undergarments and layettes for the flood victims and an equal amount was placed in the hands of a relief committee to be used in meeting the immediate, urgent needs of members living in the overflowed territory. A third thousand was subscribed for Rehabilitation Corporation stock but this was never called.

A substantial free-will offering was made by the members to meet the immediate needs of Dr. J. D. Westmoreland of Murphy, whose heroic work had been the means of saving many lives and alleviating much suffering, while costing him practically all of his own possessions.

Finances had the floor at the **1928** meeting and the question of an increase in dues came up for consideration. The Mississippi tax for membership in the Medical Association has always been a light one compared with that in other states, and yet there has never been a lack of necessary funds when something out of the ordinary was needed. But two-thirds of a total year's income had been given away the year before and there had been a considerable increase in the cost of many things, so an increase in dues amounting to thirty-three and a third percent was suggested and the amendments to the Bylaws necessary for such action was passed the following year.

A loss of membership on this account was generally predicted, but the activity of the president was such that an actual, though small, increase was shown for **1930**, in which year the meeting was in Vicksburg, by way of recompensing that city for the loss of the 1927 session, and, as is customary when visitors are in that historic place, the Association relaxed to a greater degree than usual and spent more time on pleasure.

In the year following, **1930-31,** routine work in organization was stressed, the only departure from the ordinary being that for the first time in the history of the Association the vice-presidents took an active part. They visited county societies, directed and encouraged county officers, assisted and advised councilors and had charge of all the details of organization work. At the same time, and working to the same ends, the editorial board succeeded in building up a greatly increased interest in the Mississippi section of the official journal *(The New Orleans Medical and Surgical Journal).* To these two factors may be attributed the success of the annual meeting, at which for the first time the registration was in excess of four hundred, a material increase over that of any previous year.

At this meeting an unusual amount of business was transacted by the House of Delegates, the chief items of interest being the creation of a committee to promote the establishment of state subsidy for small community hospitals, and a resolution instructing the Committee on Public Policy and Legislation to follow the guidance of the American Medical Association in matters of National legislation.

A special meeting of the House of Delegates was called by President John C. Culley of Oxford, and met at the Edwards Hotel in Jackson. A quorum of more than twenty were present. The purpose of this meeting was to change the meeting date of the State Medical Association from May 10-12 to April 12-14. This was done.

The twenty-ninth annual session of the House of Delegates was called to order at eight o'clock on the morning of April 12, **1932** by President Culley in the convention hall of the Robert E. Lee Hotel, Jackson. Seventy members of the House answered the first roll call. This was probably the largest attendance at the first session of any annual meeting of the House.

Doctor E. W. Cooper resigned as treasurer in 1931, and President Culley appointed E. L. Wilkins of Clarksdale as treasurer. Councilor W. G. Gill of the 6th District died, and President Culley appointed H. Lowery Rush to act as councilor. The date for becoming delinquent was changed to February 1 in 1931. The Secretary, Doctor T. M. Dye, recommended that it be changed back to April 1.

The thirtieth annual session of the House of Delegates of the Mississippi State Medical Association was called to order by President Acker in the convention hall of the Robert E. Lee Hotel, Jackson, at eight o'clock on the morning of May 9, **1933**. Forty-five delegates were present. Immediately after adjournment of the 1932 session, Vice-President B. S. Guyton resigned. President Acker appointed R. B. Cunningham of Booneville in his stead. Dr. J. P. Wall was introduced as speaker of the House. The Historian's report was quite long and he was having trouble as usual in getting biographies and pictures of the past presidents. He also advocated changing the term of office for Historian from five to three years. This was E. W. Howard's last meeting, for he died one month later.

The official organ of the Association at this time was the *New Orleans Medical and Surgical Journal*, and due to a loss of pay for advertising, the *Journal* was losing money. An effort was made to get as good of material to

THE MISSISSIPPI DOCTOR

VOLUME 8. BOONEVILLE, MISSISSIPPI, JANUARY, 1931 NUMBER 7.



The last photograph ever made of Dr. Bolivar Smith, astride his favorite "Dolly" who, during the past many years had carried him thousands of miles to visit the sick and afflicted, and over many a hill and dale on his favorite sport, the fox hunt.

THE COUNTRY DOCTOR

HERE is the likeness of a typical family physician who possessed a double portion of the noblest traits of heart and mind. For almost a half century he cast the bread of service upon the human ocean of life. No doubt he found much floating up around the Gate Way awaiting him, with much more to follow.

In the science of medicine he was safe; in the philosophy of life he was schooled; in kindly deeds and valuable citizenship his equals have surely been exceedingly few.

We feel keenly his absence. We take courage from the atmosphere charged by his personality.

—THE EDITOR.

publish as possible without publishing poorly prepared material. All eighty-two counties had an editor and each editor was graded on his activities by the number of articles sent in for publication.

The Committee on Public Policy and Legislation reported that it had prepared, introduced and succeeded in passing H. B. 787. This bill dealt with the practice of medicine without a license and the penalties for so doing. It became a law on May 18, 1932.

The Committee on Constitution and Bylaws was quite active also, and made some pertinent suggestions, one of which pertained to contract practice. A resolution was adopted opposing the paying of sales tax by physicians in their practice.

The thirty-first annual session of the House of Delegates met in the roof garden of the Eola Hotel at Natchez, at eight o'clock on the morning of May 8, **1934**, President ; J. W. O. Dicks presiding. The year of 1934 was an eventful one in many ways. Dr. Lippincott was acting Historian, having been appointed by Dr. Dicks to fill the office following the death of Dr. Howard. The Council and other officers met with the State Board of Public Welfare in Jackson on November 9, 1933, and formulated a satisfactory fee schedule for the Federal Emergency Relief. County medical societies were being organized to care for the administration of the relief assignment.

There was an unusually large amount of legislation before the **1934** session of the Mississippi Legislature in which the medical profession and State Board of Health were interested. The Committee on Public Health, composed of Henry Boswell, Felix Underwood and W. H. Anderson, was very active. So much was done successfully and so much attempted that it would be impractical to attempt to cover all of it without almost copying the transactions, Here are a few bills of interest: 1. Creation of an administrative board for all charity hospitals, insane hospitals, eleemosynary schools, and Ellisville Colony, and abolish our present boards governing each; 2. Incorporation into the sales tax proviso that physicians would not have to pay sales tax on gross income.

At this meeting considerable attention was paid to the need of physicians of the state for postgraduate study. The Association resolved to work out a plan or program which would provide postgraduate work for the physicians of the state. This was done. The Commonwealth Fund cooperated financially with the State Board of Health and Tulane University of Louisiana. It was desired that the program get under way no later than July 1, 1934.

The thirty-second annual session, **1935**, of the House of Delegates met in the pavilion of the Buena Vista Hotel at Biloxi, at eight o'clock on the morning of May 14, 1935. Sixty-three members of the house were present, E. C. Parker, President; J. P. Wall, Speaker.

Dr. T. M. Dye, Secretary, made a short report and recommended that the services of a secretary to record the discussions be dispensed with, since all of these discussions had to be rewritten anyway before they could be published. The Historian, Dr. Lippincott, asked for help from the Association in getting information that would help to provide a picture of the actual condition of the times. I just wonder if he got much help, and if he did, I wonder what he did with it.

The *Mississippi Doctor* was adopted as the official organ of the Association, effective January 1, 1936.

The thirty-third annual session, **1936**, of the House of Delegates met in the ballroom of the Greenville Hotel, Greenville, at eight o'clock on the morning of May 5, 1936, Dr. J. R. Hill presiding. Dr. T. M. Dye being absent due to illness, Dr. W. H. Frizell moved that Dr. N. C. Knight of Clarksdale be elected secretary pro tem, which was duly seconded and carried. There were fifty-seven members present.

The thirty-fourth annual session of the House of Delegates of the Mississippi State Medical Association met in the Convention Hall of the Lamar Hotel, Meridian, at eight o'clock on the morning of the 11th of May, **1937**, President Harvey F, Garrison, presiding. Forty-seven members were present, J. P. Wall, Speaker.

Dr. Wall suggested that "just a year ago this organization was plunged into deep gloom because of the serious illness of a man we all love, and that at this time we thought it would be a nice thing to recognize our Secretary, and tell him how glad we are he is back with us."

The thirty-fifth annual session, **1938**, of the House of Delegates of the Mississippi State Medical Association met in the Convention Hall of the Robert E, Lee Hotel, Jackson, Mississippi, at eight o'clock on the morning of the 19th of April, 1938, W. L. Little, President; J. P. Wall, Speaker. Roll call showed forty-seven members present. The Committee on Constitution and Bylaws submitted the following report: There is one change in the Constitution, Article 5, Section 2 reads as follows: "The time for the meeting of this Association shall be the second Tuesday in May of each year." Section 3 then shall read: "The place for holding the annual session of this Association shall be fixed by the House of Delegates at each annual meeting, but in emergencies, the Council shall have power to fix or to change either the time or the place or both of the annual sessions."

EDWARDS HOTEL

"MISSISSIPPI'S BEST

400 ROOMS



400 BATHS

For nearly three-quarters of a century the Jackson Home of the Doctors of the state of Mississippi—Always their Convention Headquarters.

EDWARDS HOTEL

John L. Ware, Manager

JACKSON, : : MISS.

OLD STYLE NEW FUL-VUE



SOMETHING

has happened to glasses

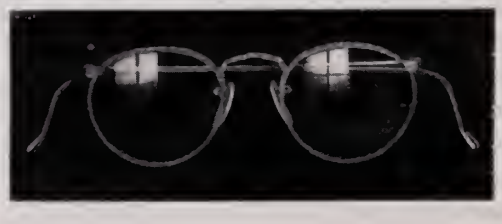
For years, all glasses were made on the same fundamental pattern. Now something has happened. Ful-vue has been designed.

Look at the picture above. It's the same girl—but wearing different glasses. On the right she is wearing the new Ful-vue frame. Note how the temples run from the top of the eye to the top of the ear in an attractive streamline. See how the eyes are revealed at the side. How much more becoming "Ful-vue" is, compared with the ordinary frame worn on the left!

See a Ful-vue frame. Try it on. We suggest that you write "Ful-vue" on your prescriptions—and wear Ful-vue yourself for greater satisfaction in your glasses.

AO

FUL-VUE



AMERICAN OPTICAL COMPANY

The thirty-sixth annual session of the House of Delegates of the Mississippi State Medical Association met in the Convention Hall of the Markham Hotel, Gulfport, Mississippi, at nine o'clock on the morning of the 9th of May, **1939**, Joe E. Green, President; J. Rice Williams, Speaker. Forty-nine members of the House were present. The secretary stated in his report that the membership of the Association for 1938 was one thousand and one, the largest recorded since 1909.

At the request of John B. Howell, W. H. Frizell introduced suggested change in Chapter 15 of the Bylaws of the State Medical Association, and introduced it with his endorsement. The Chapter as changed reads as follows: "The fiscal year of this Association shall begin April 1st each year, but the fiscal year of its component Societies and in so far as pertains to Medico-Legal Defense protection, shall begin with the calendar year, January 1st." This was referred to the Committee on Constitution and Bylaws.

The following resolution was offered by E. Leroy Wilkins: " Resolved that the Historian is hereby directed to proceed with the publication of the history of this Association in book form, to include provision for the loose leaf addition of pages of future history, if practical, and to provide one copy to each member of the Association, and Be It Further Resolved, that an assessment of $2.00 per member be collected with the dues for the year of 1940, to defray the cost of publication of the History." Its adoption was moved, which motion was duly seconded and carried.

The thirty-seventh annual session, **1940**, of the House of Delegates of the Mississippi State Medical Association met in the Convention Hall of the Robert E. Lee Hotel, Jackson, Mississippi, at nine o'clock on the morning of the 14th of May, **1940**, J. P. Wall, President; J. Rice Williams, Speaker. Fifty-three members of the House were present. A great deal of discussion came up at this session concerning Medico-Legal Defense protection.

The thirty-eighth annual session of the House of Delegates of the Mississippi State Medical Association met in the Pavilion of the Buena Vista Hotel, Biloxi, Mississippi, at nine o'clock on the morning of the 13th day of May, **1941**, W. H. Anderson President; J. Rice Williams, Speaker. Fifty-eight members were present. A vote of appreciation was extended to the U.S. Senate and to Senator Bilbo for their action in designating June 22 each year as "Doctor's Day. There was lengthy discussion as to whether or not AMA delegates should be elected at annual session to serve that term or the year thereafter or elected another time during the year due to the short notice permitted to attend the AMA meeting the week following annual session.

The thirty-ninth annual session of the House of Delegates of the Mississippi State Medical Association met in the Convention Hall of the Robert E. Lee Hotel, Jackson, Mississippi, at nine o'clock on the morning of May 11, **1942**, A. Street, President; J. Rice Williams, Speaker. Forty-nine members were present. Because most of the resolutions were declined, there was little accomplished. The suggestion that a tattoo code be put into use for the purpose of designating individuals affected with diabetes, epilepsy and serum sensitivity was referred to further study. A resolution passed that the U.S. government be urged to plan and to arrange immediately for the establishment of a central authority with representatives of the civilian medical profession, to be known as the Procurement and Assignment Agency for Physicians of the Army, Navy, and Public Health Service and to care for civilian industrial needs of the nation. The purpose of the committee was to make recommendations, based on facts, for the most effective placement of physicians for the vast national defense program.

The Fortieth annual session of the House of Delegates of the Mississippi State Medical Association met in the Victory Room of the Heidelberg Hotel, Jackson, Mississippi, at nine o'clock on the morning of May 11, **1943**, H. Lowry Rush, President; J. Rice Williams, Speaker. Thirty-nine members were present. The following resolution was adopted: "Resolved that the State Medical Association endorse the erection and support of a Class A college provided that it can be set up free of political domination to insure its practical operation."

The forty-first annual session of the House of Delegates of the Mississippi State Medical Association convened in the Convention Hall of the Robert E. Lee Hotel, Jackson, Mississippi, on May 9, **1944** at nine o'clock, Leroy Wilkins, President; J. Rice Williams, Speaker. Thirty-nine members were present.

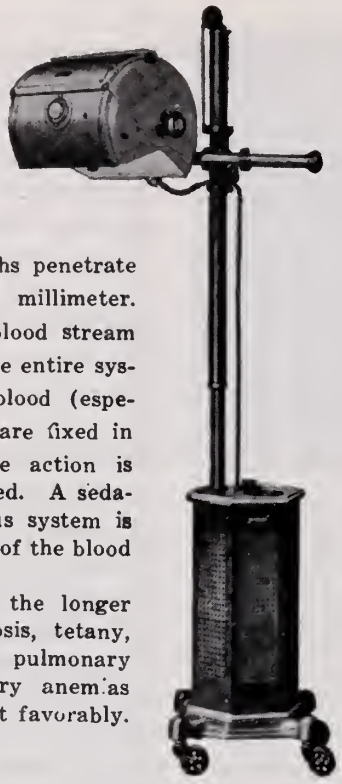
The officers of the Mississippi State Medical Association met at the Robert E. Lee Hotel in Jackson on Tuesday, May 8, **1945**. Thirty-six answered present on the roll call. The following excerpt is taken from the secretary's report: "When the federal authorities would not permit us to meet as a full House of Delegates, we conceived the idea of having these few men gather together for the purpose of trying to carry on for another year. I have no suggestions to offer as to how this can be done, but will leave it to your good judgment."

The forty-third annual session of the House of Delegates of the Mississippi State Medical Association convened in the Convention Hall of the Robert E. Lee

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The longer Ultra-violet wave lengths penetrate the skin to a distance of about 1 millimeter. Through prompt absorption by the blood stream the rays exert a marked effect upon the entire system. The mineral elements in the blood (especially calcium, phosphorus and iron) are fixed in their normal proportions.. Endocrine action is stimulated and the lymph flow increased. A sedative effect on the sympathetic nervous system is noted. The natural germicidal powers of the blood are strengthened.

Rachitis calls for irradiation with the longer Ultra-violet rays. Surgical tuberculosis, tetany, most dematoses, and many cases of pulmonary tuberculosis are benefited. Secondary anemias and general debilitated conditions react favorably.

SUPER-STANDARD MODEL

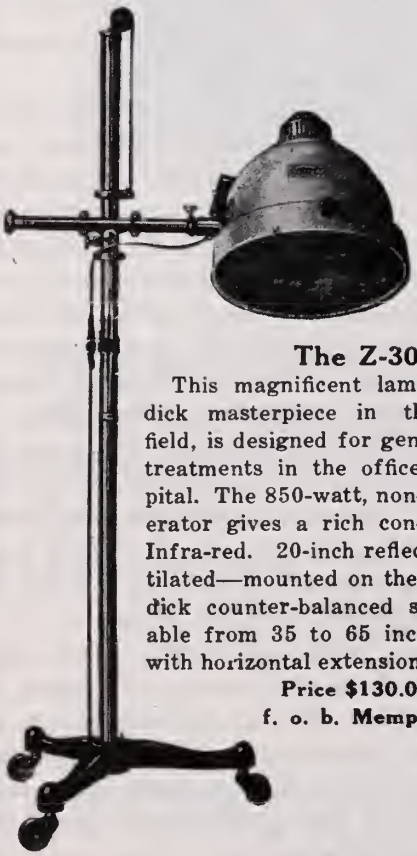
This splendid instrument delivers a rich concentration of the long Ultra-violet wave lengths to the area treated. Your voltmeter and voltage regulator give you accurate measurement on your Ultra-violet dosage. The steel tape, with spring return, measures skin distance exactly. The Uviarc quartz burner keeps the Ultra-violet intensity constant. The well-ventilated casing is mounted on the Burdick counter-balanced stand with a horizontal extension. Shadowless reflection and concealed wiring are features of the casing.

This graceful lamp moves easily upon rubber-tired casters. Its great convenience and its perfect adaptability recommend it to the physician whose office is equipped in a thoroughly up-to-date manner. Its efficiency has been tested and proved in actual experience.

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$460.00
f. o. b. Memphis

For Infra-red Therapy the BURDICK ZOALITE

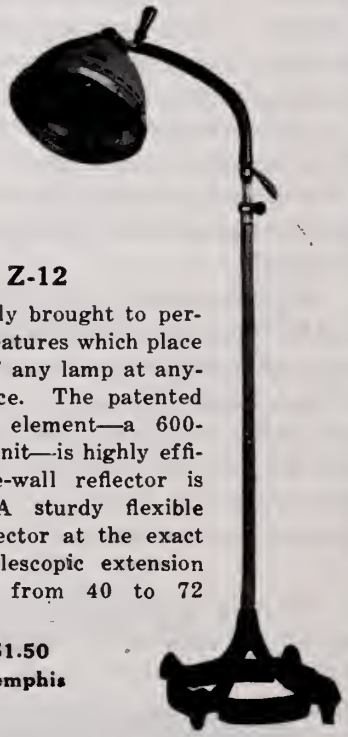
The Zoalite is the cleanest, safest and most reliable method of applying penetrating heat—for the relief of congestion and pain. Thousands of case reports prove its effectiveness in a variety of disease conditions.



The Z-30

This magnificent lamp—The Burdick masterpiece in the Infra-red field, is designed for general systemic treatments in the office or the hospital. The 850-watt, non-metallic generator gives a rich concentration of Infra-red. 20-inch reflector, full ventilated—mounted on the famous Burdick counter-balanced stand, adjustable from 35 to 65 inches in height with horizontal extension of 15 inches.

Price $130.00
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THE Z-12

The Z-12, recently brought to perfection, possesses features which place it far in advance of any lamp at anywhere near its price. The patented Burdick single-bar element—a 600-watt non-metallic unit—is highly efficient. The double-wall reflector is fully ventilated. A sturdy flexible arm holds the reflector at the exact angle desired. Telescopic extension gives adjustment from 40 to 72 inches in height.

Price $51.50
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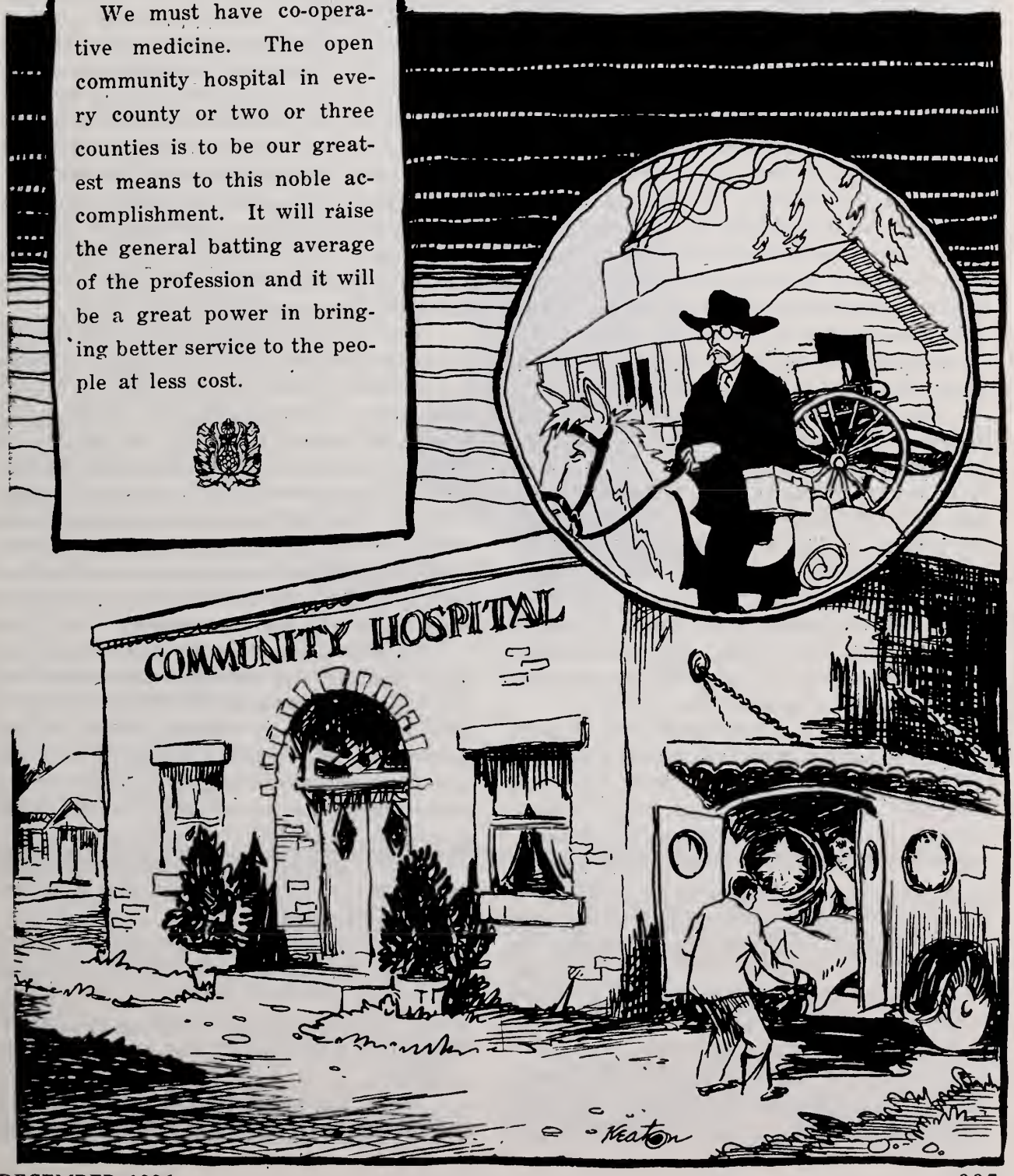
Medical Arts Building
MEMPHIS

The MISSISSIPPI DOCTOR

VOL. 8 FEBRUARY, 1931 NO. 8

The great challenge to the profession is to deliver modern medicine to the masses at a reasonable price.

We must have co-operative medicine. The open community hospital in every county or two or three counties is to be our greatest means to this noble accomplishment. It will raise the general batting average of the profession and it will be a great power in bringing better service to the people at less cost.



Hotel, Jackson, on May 14, **1946**, at nine o'clock, B. Lampton Crawford, President; J. Rice Williams, Speaker. Fifty-eight members were present. The following proposed amendment to the Constitution was read: "Article V., Section 3. In extreme emergencies as war, pestilence, etc., the Council and a quorum of the House of Delegates, or the Council alone may meet at the regular time of the annual session and shall have the power to transact such business of the Association as the exigencies of the occasion demands and their acts shall be legal and binding on the Association."

The forty-fourth annual session of the House of Delegates of the Mississippi State Medical Association convened in the pavilion of the Buena Vista Hotel, Biloxi, Mississippi, on May 6, **1947**, at nine o'clock, J. K. Avent, President; J. Rice Williams, Speaker. The following amendment to the Constitution was introduced: Amend Article VI by adding Section 4 as follows: "In case of the death, resignation, or removal from office of the president, the president-elect shall automatically ascend to the office of the president for the remainder of the term, and the assuming of this duty shall in no way disqualify him for the office for which he was elected."

The Forty-Fifth Annual Session of the House of Delegates of the Mississippi State Medical Association convened in the convention hall of the Robert E. Lee Hotel, Jackson, on May 11, **1948,** Paul Gamble, President; J. Rice Williams, Speaker. The following motion was made by J.P. Wall: "I move that our Historian, Dr. Thompson, be authorized to pay for the pictures (History of the MSMA) mentioned in his report; if there is not enough money in the fund to pay for them, it should be supplemented out of the General Fund." The motion was seconded and carried. Dr. J. Rice Williams was named Speaker Emeritus of the Association for life.

The Forty-Sixth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Buena Vista Hotel, Biloxi. May 10-12, **1949**, R.B. Caldwell, President; Stanley A. Hill, Speaker. Resolutions were adopted supporting a $25.00 assessment of each member of the American Medical Association to conduct a public relations campaign to inform the American people of the achievements of medicine and urging Mississippi's Congressional Delegation to oppose any form of compulsory health care. Mississippi Blue Cross-Blue Shield, which had been endorsed by the Association, reported that after 16 months of operation 34,000 Mississippians had been enrolled.

The Forty-Seventh Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Robert E. Lee Hotel, Jackson, May 9, **1950**, B.B. O'Mara, President; Stanley A. Hill, Speaker. It was reported that legislation supported by the Association to construct a four year medical school at Jackson had passed the Mississippi Legislature. The Second Edition of the History of the Mississippi State Medical Association was reported published. The Bylaws of the Association were amended to provide that "Members of this Association shall pay the dues of the American Medical Association."

The Forty-Eighth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Buena Vista Hotel, Biloxi, May 15-17, **1951**, B.S. Guyton, President; Stanley A. Hill, Speaker. A Medical Education Committee reported on its visits to medical schools throughout the country with members of the State Building Commission and made recommendations to assist in the building and staffing of the University of Mississippi School of Medicine in Jackson. A most important item was approved with the establishment of a permanent office and staff for the Association.

The Forty-Ninth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Robert E. Lee Hotel, Jackson, May 13, **1952,** James G. Thompson, President; Stanley A. Hill, Speaker. Mr. Rowland B. Kennedy was introduced as Executive Secretary, and the Association's first permanent office was located in the First Federal Building, Jackson. A ten point public relations program was adopted to be carried out by the Executive Secretary and a Public Relations Committee composed of members of the Association. Dr. T.M. Dye of Clarksdale was named Secretary Emeritus of the Association for life.

The Fiftieth Annual Session of the House of Delegates of the Mississippi State Medical Association was convened at the Buena Vista Hotel, Biloxi, May 11-14, **1953**, Lamar Arrington, President; Stanley A. Hill, Speaker. The House approved obtaining a plot of one acre of state ground in the neighborhood of the medical school in Jackson for the construction of an office for the Association and received a report on activities of an Emergency Medical Service Committee organized by the Association to coordinate medical aspects of civil defense and other disasters.

The Fifty-First Annual Session of the House of Delegates of the Mississippi State Medical Association was convened at the Heidelberg Hotel, Jackson, May 11-13, **1954**, M.Q. Ewing, President; Stanley A. Hill, Speaker. Among many resolutions discussed, two major actions were taken:

•Approved a permanent committee to purchase land on Riverside Drive in Jackson and to proceed with



While the quality of medical practice was rapidly improving in Mississippi, this photo taken in 1953 of Seth Ballard, herb doctor, serves as a reminder of quackery. Grandfather clauses in the licensing acts guaranteed that thousands of poorly trained physicians would continue to practice. In the 1920s the LITERARY DIGEST, LADIES' HOME JOURNAL and other magazines ran exposés on diploma mills which revealed the weaknesses in licensing boards at the time. Two states, Connecticut and Missouri, were notorious for issuing bogus medical degrees and licenses.

A reporter for the St. Louis Star in 1923 applied to a diploma mill posing as a coal salesman looking for an easier job. For $25 he obtained a high-school diploma and for $1,200 he was given a medical diploma. Missouri, which had a long history of disreputable medical colleges, as late as the 1920s had a large number of institutions rated among the worst in the country by the AMA's Council on Medical Education. While journals and newspapers contributed to the fight, the major battle against quacks and abuses in the drug field was fought by the AMA. At the 1964 Annual Session AMA President Oliver Field addressed the MSMA against "Quackery in Medicine." Photo printed with permission, Mississippi Department of Archives & History.

construction of offices for the Association.

•Approved a five year contract for continued publication of the *Mississippi Doctor* as the official organ of the Mississippi State Medical Association after which time the magazine would become the property of the Association.

The Fifty-Second Annual Session of the House of Delegates of the Mississippi State Medical Association was convened at the Buena Vista Hotel, Biloxi, May 10-12, **1955**, Cummings H. McCall, President; Stanley A. Hill, Speaker. The House of Delegates adopted these major actions:

•Endorsed organization of the Mississippi Nursing Scholarship Foundation and appointment of an Association representative to serve on the executive committee of the Foundation.

•Approved a proposed Autopsy Law for Mississippi.

•Retired the then official gavel of the Association presented by the Adams County Medical Society in 1908 and adopted a gavel made from a timber of the building in Jackson in which Dr. Joseph Golberger "made his initial

and important findings on pellagra" in 1912-1914.

•Adopted a resolution addressing the distribution, use and further evaluation of the Salk Polio Vaccine in Mississippi.

The Fifty-Third Annual Session of the Mississippi State Medical Association was convened at the Heidelberg Hotel, Jackson, May 8-10, **1956**, S. Lamar Bailey, President; Stanley A. Hill, Speaker. The 100th anniversary year of the Association 's founding was acknowledged and the Association's new office on Riverside Drive in Jackson was dedicated. As a result of actions taken by delegates of the Association:

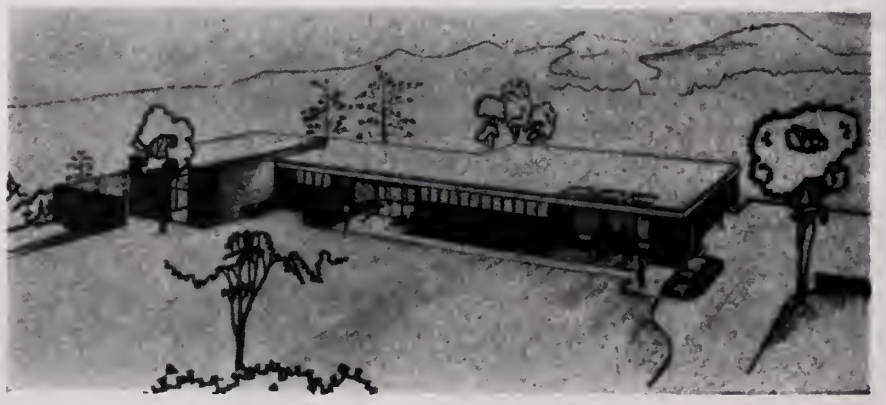
•Adopted guidelines for medical society grievance committees.

•Invited the National Rural Health Conference to meet in Jackson in 1958.

YOUR NEW BUILDING

To help observe its one hundredth year, the Mississippi State Medical Association has constructed a permanent home. A carefully developed project, the Central Office Headquarters Building was erected on a choice building site owned by the members at 735 Riverside Drive in the new medical center area. The building, designed by Jay T. Liddle, A.I.A., Jackson, was built by the Robert Kelly Construction Company of Raleigh. The steel and masonry structure contains over 4,400 square feet, providing office space and conference facilities for the Council and association committees.

The idea of a permanent association home was first advanced during the 1951-52 year and brought before the House of Delegates by Dr. D. L. Hollis, Chairman of the Budget and Finance Committee. Subsequently, the Planning Committee studied the proposal for two years, recommending that the project be carried through. The building site was acquired in 1954 and the building begun after final approval by the House of Delegates in 1955. Members of the Building Committee are Dr. James Grant Thompson, Jackson, who was President of the association during 1951-52; Dr. Stanley A. Hill, Corinth; and Dr. L. T. Carl, Jackson.



2

The original MSMA building prior to additions- from the 100th Anniversary program of the 1956 Annual Session in which the Association's founding was acknowledged and the building dedicated.

•Authorized a study of maternal mortality in Mississippi by a Committee on Maternal and Child Care.

The Fifty-Fourth Annual Session of the Mississippi State Medical Association was convened at the Buena Vista Hotel, Biloxi, May 14-16, **1957**, H.C. Ricks, President; Stanley A. Hill, Speaker. As a result of actions taken by delegates, the Association:

•Approved the Association's contracting with the Department of Defense to administer professional service benefits under the Dependents Medical Care Act (Public Law 84-569).

•Approved chartering the Pearl River County Medical Society as the 16th component medical society of the Association.

The Fifty-Fifth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Heidelberg Hotel, Jackson, May 13-15, **1958**, Howard A. Nelson, President; Stanley A. Hill, Speaker. As a result of actions taken by delegates, the Association:

•Approved organization of "A Postgraduate Education Speakers Bureau" sponsored by the Association nd University of Mississippi School of Medicine.

The Holmes County Community Hospital Medical Staff held its meeting in the dining hall of the hospital Friday night at 8:30 P.M. this July 19, 1957. All active staff members were present. Dr. P. B. Brumby, Chief of Staff, conducted the meeting which was primarily called at this time to accept three new physicians to the medical staff and secondly, to agree on changes in professional charges.

The motion to accept Dr. J.D. Mitchell and Dr. J.E. Roberts of Lexington and Dr. A. B. Cobb of Pickens to the staff was approved. Dr. Brumby informed the three members that he would introduce them for membership at the next meeting of the North Central Medical Society which in turn would entitle them to State Medical Association and American Medical Association membership.

The second order of business concerned fees, and listed below are the new charges agreed upon by Drs. Brumby, Cobb, Gowan, Mitchell and Roberts.

It was also agreed by all that these fees would go into effect as of July 20, 1957:

1. Office call $3.00
2. House call ..... $4.00 (inside city limits)
3. Hospital visits $3.00
4. Injections $1.00

(these include the usual routine such as penicillin, combiotic, vitamins, hormones, etc. Special injections which are higher in price to the physician such as ACTH, Cortisone, etc., will be higher according to the physician's own judgement.)

5. House calls (County) $4.00
   plus .50 per mile (one way) plus charges for injections
6. OB's $50.00
   (Multipara Normal)

From the "Business Minutes" of the Holmes County Community Hospital of July 19, 1957.
-The Holmes County Community Hospital Medical Staff.

•Approved reorganization of the Association's Councils and Committees.

The Fifty-Sixth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Buena Vista Hotel, Biloxi, May 12-14, **1959**, Guy T. Vise, President; B.B. O'Mara, Speaker. As a result of actions taken by delegates, the Association:

•Adopted "Guiding Principles for Medical Aspects of Workmen's Compensation" developed by the Association's Committee on Industrial Health.

•Authorized expansion of the Association's office building.

•Adopted a six point AMA statement addressing problems of the aging.

The Fifty-Seventh Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Heidelberg Hotel, Jackson, May 10-12, **1960**, Stanley A. Hill, President; Lawrence W. Long, Speaker. Among items reported:

•The first issue of the *Journal Mississippi State Medical Association* was reported published in January, 1960.

•It was reported that representatives of the Association had testified against enactment of the Forand Bill (H.R. 4700) before a Congressional Committee in Washington.

As a result of actions taken by delegates, the Association:

•Supported adoption of a uniform claim form for physicians' services.

The Fifty-Eighth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Buena Vista Hotel. Biloxi. May 9-11, **1961**, G. Swink Hicks, President; B.B. O'Mara, Speaker. As a result of actions taken by delegates, the Association:

•Endorsed the Kerr-Mills Law (P.L. 86-778) to provide medical payments on behalf of the medically-needy aged.

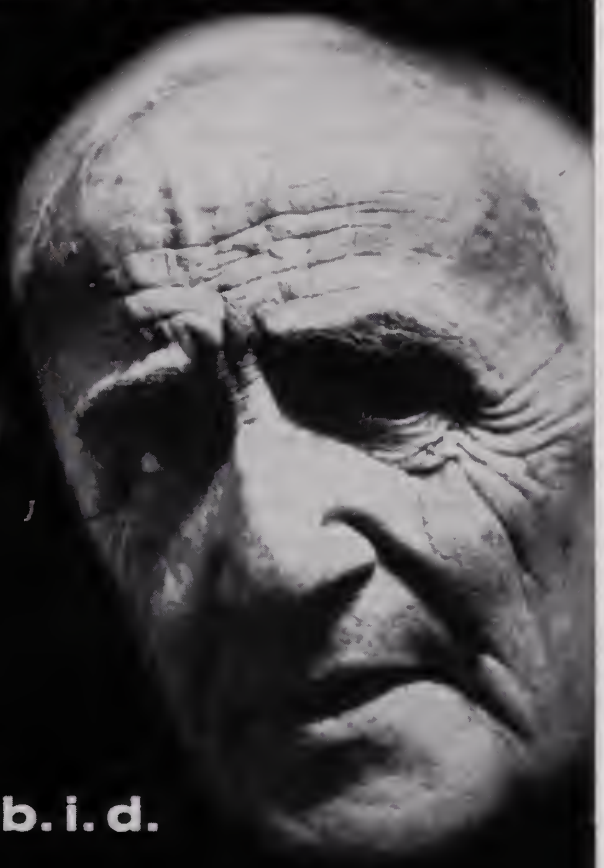
•Endorsed fluoridation of public water supplies as a preventive health measure.

•Directed that the membership be polled to determine if a study of relative values of professional fees should be conducted.

•Adopted criteria for sterilization procedures requested by patients.

The Fifty-Ninth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Heidelberg Hotel, Jackson, May 7-10, **1962**, Lawrence W. Long, President; B.B. O'Mara, Speaker. In the 1962 House of Delegates these actions were taken:

IN SENILE CONFUSION . . .



CONTINUOUS CEREBRAL OXYGENATION

WITH

ONE

Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio

•Commended the officers of the Association and Council on Scientific Assembly for the presentation of a "Space Medicine Symposium" during the annual session.

•Called on the University of Mississippi School of Medicine to investigate the feasibility of establishing teaching programs in the state charity hospitals.

The Sixtieth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Buena Vista Hotel, May 13-16, **1963**, C.P. Crenshaw, President; B.B. O'Mara, Speaker. As a result of actions taken by delegates, the Association:

•Adopted the Mississippi Interprofessional Code for Physicians and Attorneys developed by the Association and the Mississippi Bar Association.

•Endorsed establishment of an Emergency Medical Care Unit at the Mississippi Legislature.

•Authorized creation of the Mississippi Medical Political Action Committee.

The Sixty-First Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Heidelberg Hotel, Jackson, May 11-14, **1964**, John G. Archer, President; B. B. O'Mara, Speaker. As a result of actions taken by delegates, the Association:

•Called for reevaluation of Blue Shield payments in light of present medical care costs.

•Reported adoption of "Guiding Principles for Relations Between the Mississippi State Medical Association and the Mississippi Hospital Association. "

•Designated Dr. H.H. McClanahan as Trustee Emeritus for life.

The Sixty-Second Annual Session of the House of Delegates of the Mississippi State Medical Association was convened at the Buena Vista Hotel, Biloxi, May 10-13, **1965**, Omar Simmons, President; William E. Lotterhos, Speaker. As a result of actions taken by delegates, the Association:

•Endorsed mechanism to establish Board Certification of physicians in Family Practice.

•Approved "A Study of Occupational Health Programs In Small Plants In Mississippi."

•Conducted a "Symposium on Parapsychology," featuring Drs. J.B. Rhine and Louisa E. Rhine of Duke University.

•Approved chartering of the Prairie Medical Society as the 17th component society of the Association.

A Special Session of the House of Delegates of the Mississippi State Medical Association was convened at the Heidelberg Hotel, Jackson, December 16, **1965**, Everett H. Crawford, President; Howard A. Nelson, Speaker. The special session was called for the purpose of considering Public Law 89-97 (Medicare). Recommendations that the Association seek to become the fiscal intermediary for Part I-B services under that law and endorse the Mississippi State Board of Health as the certifying agency for institutional services were adopted.

The Sixty-Third Annual Session of the Mississippi State Medical Association convened at the Heidelberg Hotel, Jackson, May 9-12. **1966**, Everett H. Crawford, President; Howard A. Nelson, Speaker. As a result of actions taken by delegates, the Association:

•Recommended that physicians in so far as possible deal directly with Medicare patients and that such patients receive Medicare benefits directly from the Medicare fiscal intermediary by presentation of a receipted bill.

•Called for medical representation and advice in any implementation of Title XIX (Medicaid) in the state.

•Established the Robins Pharmaceutical Compamy/ MSMA Community Service Award to provide recognition to members of the Association, who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

The Sixty-Fourth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Buena Vista Hotel, Biloxi, May 15-18, **1967**, James T. Thompson, President; Howard A. Nelson, Speaker. As a result of actions taken by delegates, the Association:

•Adopted a six-point policy on implementation of Title XIX (Medicaid) in Mississippi.

•Authorized expansion of the Association's office in Jackson.

•Presented a special plaque to Dr. J.D. Williams, Chancellor, University of Mississippi, in appreciation of his service to the State and to the medical profession as demonstrated by his interest and support for the University of Mississippi School of Medicine.

The Sixty-Fifth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Heidelberg Hotel, Jackson, May 13-16, **1968**, Temple Ainsworth, President; William E. Lotterhos, Speaker. As a result of actions taken by delegates, the Association:

•Adopted a report on continuing medical education in Mississippi which called for a Mississippi Postgraduate Institute sponsored by the Association and University Medical Center.

•Commended the Medical Television Department of Smith, Kline and French Laboratories for televising portions of the Annual Session's scientific program live from the University of Mississippi School of Medicine.

•Approved a report of the Board of Trustees calling for separate Blue Cross and Blue Shield corporations in Mississippi in lieu of the Association's withdrawing its endorsement of the Mississippi Hospital and Medical Service, Inc.

•Approved organization of the Singing River Medical Society as the 18th component society of the Association.

The Sixty-Sixth Annual Session of the Mississippi State Medical Association convened at the Buena Vista Hotel, Biloxi, May 12-15, **1969**, Joseph B. Rogers, President; William Lotterhos, Speaker. As a result of actions taken by the Association:

•Received an official MSMA flag from the past presidents of the Association.

•Endorsed legislation permitting physicians to incorporate their practices.

The Sixty-Seventh Annual Session of the Mississippi State Medical Association convened at the Buena Vista Hotel, Biloxi, May 11-14, **1970**, James L. Royals, President, William E. Lotterhos, Speaker. As a result of actions taken by the Association:

•Urged the state to increase the number of medical students graduating from the University of Mississippi School of Medicine.

•Approved direct billing for county, state and AMA dues by the Association.

•Supported legislation to legalize abortions when performed because pregnancy threatened the health of the mother or there was a probability that the infant would be born deformed.

The Sixty-Eighth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Sheraton-Biloxi, May 3-6, **1971**, Paul B. Brumby, President; John B. Howell, Vice Speaker. As a result of actions taken by the Association:

•Approved establishment of the Mississippi Foundation for Medical Care to conduct peer review and adjudication of third party claims.

•Endorsed establishment of a Department of Family Practice at the University of Mississippi School of Medicine.

•Called for establishment of a State Medical Examiners Office.

The Sixty-Ninth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Sheraton-Biloxi, May 8-11, **1972**, Arthur E. Brown, President; William E. Lotterhos, Speaker. As a result of actions taken by the Association:

•Endorsed legislation to require health insurance coverage for newborn infants.

•Commended Mr. Rowland B. Kennedy for his twenty-two years service to the Association as Executive Secretary.

The Seventieth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Sheraton-Biloxi, April 30-May 3, **1973**, Charles R. Jenkins, President; John B. Howell, Speaker. As a result of actions taken the Association:

•Supported legislation to provide an expanded role for the qualified nurse based on approval by the Mississippi State Board of Health (Licensing Board) and Mississippi Board of Nursing.

•Approved a program for accrediting instate institutions and organizations providing CME programs to physicians.

•Directed the Mississippi Foundation for Medical Care to proceed to organize a Professional Standards Review Organization under requirements of Public Law 92-603.

•Appointed a committee to study realignment of the Association's trustee districts and limitation of terms of office.

The Seventy-First Annual Session of the Mississippi State Medical Association convened at the Sheraton-Biloxi, May 6-9, **1974**, Arthur A. Derrick, Durant, President; Walter H. Simmons, Speaker. As a result of actions taken by the Association:

•Approved election of an additional trustee from Association district five.

•Appointed a committee of the House of Delegates to study and recommend improvements in organization of the component societies.

The Seventy-Second Annual Session of the Mississippi State Medical Association House of Delegates convened at the Sheraton-Biloxi, May 5-8, **1975**, J.T. Davis, President; Walter H. Simmons, Speaker. As a result of actions taken the Association:

•Directed that legal action be initiated to terminate apparent practices of chiropractors in the state which violate provisions of the chiropractic licensing act and result in the practice of medicine without a license.

•Approved initiation of a legislative program to address the crisis in medical malpractice.

•Approved a study of alternatives to the present professional liability insurance market.

A Special Session of the House of Delegates of the Mississippi State Medical Association was convened at Primos Northgate Restaurant, Jackson, October 23, 1975, Jack A. Atkinson, President; C.D. Taylor, Jr., Speaker. At the special session delegates took these actions:

•Adopted a legislative program directed at alleviat-

ing the crisis in medical malpractice suits.

•Directed the Board of Trustees to proceed to organize a nonprofit physician owned corporation to provide professional liability insurance.

The Seventy-Third Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Holiday Inn Downtown Jackson, May 3-6, **1976**, Jack A. Atkinson, President; C. D. Taylor, Speaker. As a result of actions taken by delegates, the Association:

•Approved appointment of a committee to evaluate and recommend resources for high risk maternal and newborn care.

•Called attention to the discriminatory and arbitrary manner in which the Mississippi Health Systems Agency, Inc. was implementing Public Law 93-641.

•Approved a public relations campaign to communicate the professional liability insurance crisis to the public.

The Seventy-Fourth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Sheraton-Biloxi, May 2-5, **1977**, Lyne S. Gamble, President; C.D. Taylor, Speaker. At the 109th Annual Session delegates heard Dr. Hugh A. Gamble, II deliver the president's address on behalf of his father, Dr. Lyne S. Gamble, who was ill and unable to attend the meeting. They also:

•Directed the Board of Trustees of the Association to take whatever legal action was necessary to assure that state statutes dealing with appointment of members of the Mississippi State Board of Health were followed by the Governor.

•Approved the election of two delegates to the House of Delegates by the House Staff Association of the University Medical Center.

The Seventy-Fifth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Coliseum Ramada Inn, Jackson, April 30-May 4, **1978**, James O. Gilmore, President; C.D. Taylor, Speaker. As a result of actions taken by delegates, the Association:

•Approved establishment of a program to identify and assist the physician disabled by alcohol and drug usage.

•Approved formulation of a plan to address health needs in Mississippi and a public opinion poll on health care sponsored by the Association.

•Re-endorsed Blue Cross-Blue Shield of Mississippi.

The Seventy-Sixth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Biloxi Hilton, May 7-10, **1979**, Carl G. Evers, President; R. Faser Triplett, Speaker. As a result of actions taken by delegates, the Association:

•Commended the Board of Trustees, Officers and Legal Counsel for defeating a suit in Federal Court by the Governor, challenging the Association's legal authority to make nominations to the Mississippi State Board of Health.

•Commended the Board of Trustees, Officers and Legal Counsel for successfully concluding a suit defining unlawful practices of a chiropractor.

•Supported a requirement for at least one year of postgraduate medical education as a prerequisite for obtaining a medical license.

•Adopted a report on "Health Needs in Mississippi" and directed that it be widely disseminated.

The Seventy-Seventh Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Biloxi Hilton, April 27-May 1, **1980**, Gerald P. Gable, President; R. Faser Triplett, Speaker. As a result of actions taken by delegates, the Association:

•Formally presented the MSMA President's Pin to the family of Dr. Robert S. Caldwell, MSMA President-elect, who died November 5, 1979.

•Urged that a co-payment be placed on all optional health services covered by Medicaid.

•Urged that both placement and operation of federally funded primary care projects be better coordinated with local private and public health resources.

The Seventy-Eighth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Biloxi Hilton, April 26-30, **1981**, Paul H. Moore, President; Carl G. Evers, Speaker. As a result of actions taken by delegates, the Association:

•Approved changing the Annual Session of the Association to a Wednesday through Sunday format in early June as soon as hotel space was available.

•Stated that the growth of HMO's should be determined not by federal subsidy, preferential federal regulation, and federal advertising promotion, but by the number of people who prefer this mode of health care delivery.

•Appointed a committee of past presidents of the Association to plan a program to commemorate the 125th Anniversary Year of the Association occurring December 15, 1981.

The Seventy-Ninth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Biloxi Hilton, May 2-6, **1982**, R. Faser Triplett, President; Carl G. Evers, Speaker. The MSMA House of Delegates took these major actions during the

meeting celebrating the Association's 125th Anniversary Year:

•Urged the State Board of Health to direct its activities toward the provision of preventive health services normally classified as public health and to assure that its activities in providing therapeutic care adhere to the highest standards of care and do not duplicate services provided by the private sector. The House of Delegates also urged closer communication between the State Board of Health and local physicians.

•Approved a dues increase of $25.00 effective with 1983 dues.

•Supported enactment of an Association-sponsored program to receive and resolve patient complaints about medical services.

•Called for appointment of a special Association committee to remove drivers under the influence of alcohol and other mood-altering substances from the highways of Mississippi.

•Supported the Mississippi Foundation for Medical Care conducting peer review on behalf of industry and third party payors.

•Approved a study of the Association's organizational structure.

•Supported enactment of collateral source legislation by the 1983 Mississippi Legislature.

•Supported an immunization campaign for congenital rubella syndrome.

•Enacted a nominating process to select and publicize candidates for vacancies in offices of the Association at least 60 days prior to the annual session.

•Adopted recommendations of the Board of Trustees that no new scientific sections be authorized and no reimbursement be made for out-of-state speakers until the Board completes a study of criteria for new and continuing sections of the Association.

•Endorsed the continuation of an annual Association conference on medical socio- economic issues.

•Endorsed the goals of the UMC Poison Services Program and urged voluntary contributions for support of the program.

•Received an amendment to the MSMA Constitution increasing the term of office of vice- president of the Association from one to three years.

•Approved transfer of Yazoo County from Central Medical Society to Delta Medical Society.

The Eightieth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, May 11-15, **1983**, Sidney O. Graves, President; Carl G. Evers, Speaker. The MSMA House of Delegates took these major actions.

•Canceled the second phase of a two-year dues increase in light of the Association's improved financial status.

•Recommended that there be physician representation on hospital governing boards, preferably as voting members.

•Approved organization of a 501(c)(9) trust to provide insurance benefits to members of the Association, their families and employees.

•Called for reasonable and nominal co-payments to be placed on all Medicaid services.

•Named Dr. Moncure Dabney of Crystal Springs Editor Emeritus of the *JOURNAL MSMA* in recognition of his long and distinguished service.

•Urged a study of the need for minimal criteria for so-called emergency care clinics.

•Urged the State Department of Health to establish a division to monitor the problems of exposure to chemicals in food, air and water.

•Expressed continued concern over expanded fee-for-service activities of the State Department of Health with respect to their possible duplication of local private health services.

•Urged that the health hazards of smoking marijuana be widely publicized to young Mississippians.

•Urged the State Board of Medical Licensure to reassess reciprocity agreements with other states in light of recent policies to license individuals who have graduated from medical schools which are not documented to have met the standards required by the Liaison Committee on Medical Education.

•Urged distribution of a uniform claim form for disability insurance similar to that for health insurance.

•Banned smoking at all official meetings of the Association.

•Funded a country doctor's office to be erected at the new Agricultural and Forestry Museum in Jackson.

•Established a Section on Emergency Medicine as one of the scientific sections of the Association.

•Increased the term of office of vice-presidents of the Association to three years.

The Eight-First Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, May 16-20, **1984**, Whitman B. Johnson, President; Carl G. Evers, Speaker. The MSMA House of Delegates took these actions:

•Adopted amendments to the MSMA Constitution and Bylaws which among other things reorganized the House of Delegates and scientific program format.

The Country Doctor Museum at the Jim Buck Ross Agricultural Museum in Jackson





The 1983 House of Delegates voted to fund this Country Doctor's Office at the Jim Buck Ross Agricultural & Forestry Museum in Jackson. Dr. John W. Melvin was born in Madison County and went in to practice with his father-in-law in Camden, MS in 1911 upon graduating from Tulane University School of Medicine. Dr. Melvin was usually paid in cash on a running account basis but it was not uncommon that he be paid with chickens, watermelons or other goods.





•Approved a building program to house the Association and its related programs, the Medical Assurance Company of Mississippi and the Mississippi Foundation for Medical Care.

•Directed the Board of Trustees to study the feasibility of setting up PPOs and/or IPAs in areas of the state where the membership and their patients desire such programs.

•Went on record to oppose storage of nuclear waste in the salt domes of Mississippi.

•Directed the Council on Medical Service to study and develop methods to judge competency of physicians to practice medicine.

•Established a hospital medical staff section which will meet at annual sessions of the Association as a forum to discuss issues affecting hospital medical staffs.

•Approved an informational brochure on breast cancer for distribution to physicians and their patients.

•Established a Council on Public Relations.

•Urged all third party payors to adopt Medicare phraseology on payments to physicians, namely "amount approved."

•Urged that studies of the effects of agricultural chemicals on fish and other wildlife be expedited.

•Restated Association support for nominal co-payments on Medicaid services.

•Restated Association support for physician representation on hospital governing boards.

•Endorsed the concept of outpatient education of patients with diabetes.

•Expressed support for a freeze on physicians' fees as previously endorsed by MSMA's Board of Trustees.

•Urged each member of the Association to use the AMA's Patient Medication Instruction (PMI) program.

•Directed that projections of an oversupply of health professionals be brought to the attention of appropriate educational and public officials in the state.

•Restated support for a medically-needy program for mothers and children under Medicaid and for adequate funding of basic required services.

•Restated support for raising the legal age for purchasing alcohol in the state to age 21.

•Adopted terminology clarifying drug substitution issues and stated opposition to any concept of therapeutic substitution of drugs by pharmacists.

•Approved a technical exhibit section beginning with the 1985 Annual Session.

•Urged all Mississippians to avail themselves of first aid training.

The Eight-Second Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, May 15-19, **1985**, Ellis M. Moffitt, President; Carl G. Evers, Speaker. A unified membership requirement went into effect with payment of 1986 MSMA dues as a result of action taken by delegates.

In recommending approval of the requirement that MSMA members also belong to their local component society and the AMA, the Association's Reference Committee on Constitution and Bylaws cited the need for a stronger federation representing a unified profession in addressing issues currently facing the profession. Central Medical Society, which endorsed the unified membership concept in April, introduced a resolution urging an MSMA bylaws amendment to provide for the requirement.

Delegates subsequently approved the reference committee report which recommended that the requirement be in force until 1989, at which time it would be continued only by affirmative vote of the House of Delegates.

In addition to adopting unified membership, the House took these other major actions:

•Approved preliminary plans for a $2 million construction project to expand the MSMA headquarters building.

•Voted to support legislation to expand the authority of the Mississippi State Board of Medical Licensure to inspect medical records of a physician on its own initiative or when a complaint based on incompetence is received from a hospital-based medical staff, component society or the MSMA.

•Voted to establish a committee to study alternative delivery programs for Medicaid recipients.

•Called on the Governor to appoint a task force to study the medical malpractice situation in Mississippi.

•Called on the Mississippi Hospital Association to join in a study of the problems facing small rural hospitals.

•Reorganized the Council on Scientific Assembly to coordinate planning for annual sessions of the Association.

•Made all MSMA general officers voting members of the House of Delegates.

•Called for a mandatory seat belt law.

•Urged that the per diem to community hospitals for indigent care be raised to the level paid state charity hospitals.

•Endorsed local government efforts to utilize community hospitals for care of the indigent.

•Directed the Board of Trustees to study methods for paying annual dues in installments.

•Appointed an ad hoc committee on membership

recruitment and directed that each MSMA member be mailed a list of non-members in his/her area and be urged to solicit these non-members to join.

•Emphasized the need to improve the health education curriculum in schools in Mississippi.

•Directed that a committee be appointed to strengthen relationships between MSMA and the UMC house staff and medical students.

The Eighty-Third Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, June 4-8, **1986**, Ralph L. Brock, President; Carl G. Evers, Speaker. The MSMA House of Delegates took these actions:

•Approved plans to fund a new office building through MSMA Services, Inc. at a cost of $2.8 million.

•Endorsed a requirement for health insurors to place a statement on beneficiaries' cards to inform patients and physicians if a certification or pre-authorization requirement exists as a condition of payment.

•Voted to have MSMA and its component societies share the expense of sending a component society representative to each annual AMA Leadership Conference.

•Urged each MSMA member to become aware of proposed cuts in federal health funds and to contact the Mississippi congressional delegation in this regard.

•Urged improved communication between Mississippi hospitals and their medical staffs on the socioeconomic environment of health care in the hospital.

•Urged each MSMA member to become familiar with the report of the Special Legislative Study Committee on Indigent Care.

•Commended Mr. Bill Simmons, Director of the Mississippi Medicaid Commission, for his effective administration of the program under increasing adverse circumstances.

•Directed that a study be done to determine the feasibility of requiring train cars to have reflectors or be painted with reflective paint.

•Supported passage of a Clean Indoor Air Act and efforts to increase public awareness of the dangers associated with the use of tobacco products.

•Reaffirmed Association support for physician representation on hospital governing boards.

•Directed that efforts be undertaken to promote a reduction in deaths and injuries related to firearms.

•Commended and supported efforts of a task force recently appointed by the State Superintendent of Education to propose a health curriculum for Mississippi's public schools.

•Restated support for enactment of a compulsory seat belt law.

•Directed that a study be conducted to determine the feasibility of requiring all employers in the state to carry health insurance on their employees.

•Supported legislation to require a health insurance pool for high-risk individuals.

•Urged that practicing physicians be used in peer review activities and have similar training to the physician under review.

•Received a report that the Association had a net increase in membership during the first year of unified membership and reaffirmed support for unified membership.

The Eighty-Fourth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, June 3-7, **1987**, W. Joseph Burnett, President; Carl G. Evers, Speaker. The MSMA House of Delegates took these actions:

•Reaffirmed and gave a "vote of confidence" for the Association's plans to establish a statewide HMO/IPA.

•Noted and urged the Board of Trustees' continued efforts to seek solutions to problems with services for a growing medically indigent population.

•Approved establishment of a Young Physicians' Section.

•Adopted a policy statement on AIDS and recommended that when a reliable test to detect AIDS carriers becomes available, an AIDS carrier be reportable just as a carrier of any other communicable disease.

•Expressed advocacy and support for a health education curriculum developed by the State Department of Health.

•Adopted guidelines for "case manager programs."

•Urged the MSMA Auxiliary to increase its political education and support activities.

•Urged support for a nationwide fee schedule for Medicare and Medicaid which would end present gross geographic differences in such fees.

•Adopted a recommendation that Medicaid eligibility be expanded to the fullest extent possible under federal guidelines.

•Supported increased funding and better organization of the State Medical Examiner's Office.

•Commended and urged all MSMA members to support the Association 's CommuniCare Program."

•Urged Medicare to more carefully edit statements to patients.

•Endorsed and urged MSMA members to support Rotary (Clubs) International "Polio Plus" project.

•Assigned the Association's Council on Medical Service responsibility for ongoing review and coordination of implementation of "The Health Policy Agenda for

the American People."

•Endorsed legislation to prohibit the use of all-terrain vehicles on public roads.

•Commended Dr. George C. Furr of Clarksdale for his efforts to determine the safety of pesticide use.

•Presented to Mrs. Stanley Hill a memorial resolution adopted by the AMA House of Delegates commending Dr. Hill for his years of service.

The Eighty-Fifth Annual Session of the House of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, June 15-19, **1988**, W. Lamar Weems, President; James C. Waites, Speaker. The MSMA House of Delegates took these actions:

•Affirmed medical tort reform as the Association's top legislative priority.

•Created a committee to establish and coordinate legislative action on care of the medically-needy.

•Endorsed and urged support for a "Senior Care Program" to assist needy medical beneficiaries to obtain medical services.

•Endorsed establishment of an "Ethics Panel" to study and serve as a resource on ethical issues.

•Approved a $25.00 dues increase in 1989 and 1990.

•Called for full expansion of the MS Medicaid Program and endorsed a proposal for congress to establish uniform eligibility and benefits for Medicaid across all states.

•Directed that a study be conducted of blood procurement and disbursement services in Mississippi.

•Directed that specialty section advisory panels be established to address utilization review, quality assurance and physician reimbursement concerns.

•Urged repeal of Medicare's "Unnecessary Services" requirements.

•Endorsed a public information program for a tobacco-free society.

•Endorsed establishment of a media awards program for excellence in reporting health care issues.

•Urged and reaffirmed support for a School Health Education Program.

•Supported efforts to end third-party coverage discrimination against any broad category of illness.

•Supported legislative action on the use of pesticides.

•Supported colocation of the MS Children's Rehabilitation Center and the Blake Clinic.

•Opposed any legislation permitting optometrists to prescribe medication for the treatment of eye or systemic diseases.

•Supported CME as a requirement for appointment or reappointment to the hospital medical staff.

•Condemned and urged relief from inequities in DRG payments to rural hospitals.

•Urged relief from inequities in Medicare payments between various areas of the country.

•Urged solutions for a shortage of long-term care beds in the state.

The Eighty-Sixth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville, Biloxi, May 31-June 4, **1989**, David R. Steckler, President; James C. Waites, Speaker. The MSMA House of Delegates took these actions: Approved the formation of a Coordinating Committee for Organized Medicine in Mississippi (i.e., MSMA, the MS Foundation for Medical Care and the Medical Assurance Company of MS).

•Removed a requirement in the MSMA bylaws that unified membership with the AMA cease after 1989.

•Established an Environmental Protection Committee to address environmental and waste disposal issues.

•Urged the AMA to assume a leadership role in developing methods to lower the cost of medical care which would be disseminated to the membership as continuing medical education.

•Requested MACM to advise on the potential effect of various tort reform measures on premium rates.

•Urged continued efforts to expand programs to care for the medically-needy and uninsured, and urged the membership to participate in Medicaid and the Association 's Senior Care Program.

•Endorsed the appointment of specialty panels to advise on medical quality and utilization issues.

•Adopted a recommended format for visits of the MSMA president to component societies.

•Urged a study of the effectiveness of legislation to regulate entities performing utilization review.

•Approved criteria for establishment of a media awards program.

•Endorsed the Association's working with other concerned organizations to stop the use of tobacco, and urged the Mississippi Department of Health to restrict the use of tobacco in health care facilities.

•Directed the Association to join the Mississippi Department of Health in a program to reduce accidental injuries.

•Urged regulation of tanning parlors.

•Restated support for adequate funding of the office of State Medical Examiner.

•Urged a study of legislation to define qualifica-

tions of expert witnesses.

•Endorsed efforts of the Council on Medical Service to serve as a resource for development of local ethics panels.

•Urged blood services organizations in Mississippi to form an advisory committee composed of MSMA and MS Hospital Association representatives.

•Directed a study of hearing screening policies of the Mississippi State Department of Health by the Association's specialty panels on EENT, pediatrics and family practice.

•Urged the AMA to seek repeal of federal legislation requiring nursing home patients to be screened for mental illness and mental retardation.

The Eighty-Seventh Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Ramada Coliseum, Jackson, May 31-June 3, **1990**, J. Edward Hill, President; James C. Waites, Speaker. The MSMA House of Delegates took these actions:

•Directed the Council on Medical Education to confer with peer review and professional liability insurance entities in MS and develop a plan for presentation to the House of Delegates at the 1991 Annual Session to provide CME at annual meetings of the Association based on identified needs of MS physicians.

•Adopted a recommendation that the Association conduct its annual meetings in late April or early May at the earliest date available, and alternate sessions between Jackson and the Gulf Coast.

•Adopted several resolutions identifying health care deficiencies in MS, urging a study of OB and perinatal services and supporting financial incentives for physicians to practice in rural areas.

•Received a report from the Association's Environmental Protection Committee which recommended regulations for infectious and medical waste and urged physicians to develop an attitude of environmental stewardship.

•Directed that a study be done to determine why physicians are leaving the state.

•Urged support for HR 4475, "The Medicare Physicians Relief Act of 1990," and commended members of the MS Congressional Delegation who sponsored the legislation.

•Commended the diligent efforts of Dr. Clinton Smith, Director of the Medicaid Program, to significantly reform and expand the program.

•Adopted an updated MSMA Policy Statement on AIDS/HIV and voiced continued support for legislation to prevent discrimination against HIV-infected persons.

•Endorsed AMA Health Access American Plan.

•Commended retiring *Journal MSMA* managing editor, Mrs. Patsy Twiner, for her work and dedication to the Association.

•Urged MSMA and its members to encourage and participate in education programs for junior and senior high school coaching staffs.

•Urged support for a program to provide comprehensive, multidisciplinary early intervention services for infants and toddlers with special needs.

•Supported a requirement that health insurance companies provide their insureds or their insureds' physician with specific claim information necessary to provide payment of benefits.

•Urged legislation to prohibit smoking by minors and to ban cigarette vending machines in Mississippi.

•Urged continuing efforts to address the issue of care of the medically-needy in the state.

•Urged continuing efforts to develop physician/patient communication projects.

•Supported the Association's efforts to develop school health education projects and a local school district medical advisers' panel.

•Urged better education and closer supervision with respect to the role of nurse practitioners.

•Urged support for enactment of HR 2276, which would prohibit "lift-chair" vendors from soliciting Medicare beneficiaries by sending them certification forms and reduce Medicare payment for "lift-chairs" by 15 percent; and urged that the AMA study the clinical indications, effectiveness and cost benefit of "lift-chairs".

•Urged the State Department of Vocational Rehabilitation to recognize and reimburse services at all institutions in the state staffed and equipped to provide rehabilitation services.

•Adopted a requirement that a Board or Council member be replaced if he/she misses two meetings annually without permission of the chairman.

The Eighty-Eighth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville Hotel, Biloxi, May 15-19, **1991**, J. Elmer Nix, President; H. Vann Craig, Speaker. The MSMA House of Delegates took these actions:

•Re-emphasized a "fair share" voluntary participation in Medicaid whereby all Mississippi physicians would provide services to a percentage of Medicaid patients in their practice that is at least equal to the Medicaid population in their respective county.

•Commended the members of the Mississippi Board of Medical Licensure and its Executive Director for their

efforts in enforcing the medical practice act.

•Directed the Council on Legislation to study the current operations of Blue Cross-Blue Shield of Mississippi and make recommendations concerning the company's exemptions from the state's insurance laws and non- participation in the state guarantee fund and the need for legislative action in the 1992 Regular Session of the Mississippi Legislature to address any existing inequities.

•Directed the Board of Trustees to pursue any means available to ensure that the Mississippi Division of Medicaid implement the OBRA'89 requirements intended to improve access to health care for children and pregnant women on Medicaid.

•Urged the AMA to continue its efforts to persuade the Health Care Financing Administration to recognize and fairly reimburse legitimate physician case management services for patients receiving home health care services.

•Endorsed legislation to require all restaurants and public buildings to be tobacco-free environments.

•Directed that findings and recommendations of the Mississippi Chapter, American Academy of Pediatrics, dealing with waste disposal be endorsed by MSMA and sent to local elected officials, hospital administrators and MSMA members, and the latter be urged to present and monitor the findings and recommendations.

•Commended and urged the membership to utilize a Medicare Advisory Committee recently appointed to resolve difficulties between physicians and the Medicare program. Also, directed publication of information on the Medicare claims renewal process in the Journal MSMA.

•Directed that the Association convey its support for improving access to health care to the Mississippi Congressional Delegation, the Governor, the Mississippi Legislature and the public and inform the Mississippi Congressional Delegation and their staff about the various proposals for improving access to health care supported by elements of organized medicine.

•Commended the Junior League of Jackson and all others who participated in the planning and construction of the Mississippi Children's Cancer Clinic and directed that a resolution be presented to the Junior League of Jackson in this regard.

The Eighty-Ninth Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Ramada Renaissance Hotel, Jackson, April 29-May 3, **1992**, James C. Waites, President; H. Vann Craig, Speaker. The MSMA House of Delegates took these actions:

•Urged a study of current home health care services by authorities responsible for oversight of such services with emphasis on medical necessity requirements, utilization and costs of the services.

•Directed the Association to take an active role in the implementation of a Medicaid drug utilization review program and to support the MS Foundation for Medical Care in its bid to provide Medicaid drug utilization review services.

•Recommended legislation to provide sovereign immunity to physicians providing uncompensated care on a voluntary basis.

•Directed that a study be conducted to determine the feasibility of having a single Medicare fee area.

•Urged that the AMA House of Delegates adopt a policy that standards, guidelines or requirements developed by government or third party entities dealing with patient care demonstrate a scientifically proven positive impact on quality of care and failing this requirement such standards, guidelines or requirements be eliminated or an adequate explanation be given as to why they are perceived to be necessary by the promulgating organization.

•Commended MSMA President, Dr. James C. Waites, for his appointment to the Practicing Physicians Advisory Council to the Health Care Financing Administration.

•Directed that the AMA Delegates' Report be highlighted and publicized to the entire membership.

•Urged MSMA members to provide educational information to their patients and community organizations on the need and importance of recreational safety helmets.

•Recommended that MSMA component societies implement "mini-internship" programs and invite local legislators and other community leaders to participate in the programs.

•Adopted a $25 dues increase effective in 1993.

•Established an ad hoc Council of Past Presidents to develop a comprehensive plan to address health care cost and access issues.

•Directed the Board of Trustees to study the availability of new locations for annual sessions of the Association beginning in 1996.

•Endorsed and commended the YWCA's operation of a Hospital Guest House in Jackson to serve the families of out-of-town patients.

•Directed the Council on Legislation to study the feasibility of seeking legislation to require the labeling of Mississippi-produced foods as "Grown in Mississippi."

The Ninetieth Annual Session of the House of

Delegates of the Mississippi State Medical Association convened at the Royal d'Iberville Hotel, Biloxi, April 28-May 2, **1993**, William C. Gates, Jr., President; H. Vann Craig, Speaker. MSMA's House of Delegates acted on a broad range of reports from the Board of Trustees and MSMA's Councils, as well as resolutions. Some of the significant actions taken by the House are:

•Directed that a MS Physicians' Service Network be established by the Association within the context of health system reform efforts to address access, quality and cost issues.

•Went on record to support legislation requiring a beneficiary co-payment for home health services and an explanation of medical benefits (EOMB) when such services are rendered.

•Directed that the advice and support of the AARP be sought for legislation requiring periodic recertification of motor vehicle operators over age 70.

•Directed the Board of Trustees to study the advisability of raising the minimum age for a drivers license in Mississippi to age 16.

•Directed the Board of Trustees to take necessary action to obtain a fair and equitable physicians' fee schedule for the Mississippi Workers' Compensation Program.

•Endorsed the National Vaccine Advisory Commission's Standards for Immunization Practice and urged all physicians to promote immunizations and actually participate in community-based efforts to fully immunize at least 90% of all children under age two.

•Presented the MSMA Community Service Award to Dr. Antone W. Tannehill, Jr. of Tupelo.

•Presented special appreciation awards to Drs. Ellis M. Moffitt and Nina Goss-Moffitt of Jackson for their work in establishing and conducting the MSMA Impaired Physicians Program.

•Directed the Council on Medical Service to study and recommend the need for a medical home for indigent children.

•Directed that a study be made of the health needs of the incarcerated.

•Adopted a new process for nominating members to serve in elected offices of the Association, whereby nominations will be solicited from the general membership and the nine immediate past presidents of the Association will serve as a nominating committee.

The Ninety-First Annual Session of the House of Delegates of the Mississippi State Medical Association convened at the Ramada Plaza Hotel, Jackson, May 11-May 15, **1994**, Don Q. Mitchell, President; H. Vann Craig, Speaker. MSMA's House of Delegates acted on a broad range of reports from the Board of Trustees and MSMA's Councils, as well as resolutions. The House of Delegates took the following actions:

•Acknowledged and commended formation of the MS Physicians Care Network (MPCN) in accordance with action by the House of Delegates at the 1993 Annual Session. MPCN now begins its second organizational phase- the marketing of the network to Mississippi employers.

•Went on record without a dissenting vote to continue unified membership with the AMA.

•Noted that a new and intermediate judicial system would be established in Mississippi and urged the membership to participate in local elections to implement the system.

•Directed that the Association closely monitor the development of a plan to establish a state Health Financing Authority combining Medicaid and public employees in a health benefits purchasing pool, the plan to be presented to the 1995 Mississippi Legislature.

•Supported enactment of a comprehensive school health education program and directed that the Association and the MSMA Alliance renew efforts to sponsor health seminars for teenagers and to have members serve as local school health education advisors.

•Directed that a study be done to determine the feasibility of the Association sponsoring an "Any Willing Provider" law in the 1995 regular session of the Mississippi Legislature.

•Urged all health benefit plans to include as a minimum the preventive health services proposed in the AMA's standard benefits package and such other preventive health services as are beneficial, cost effective and affordable.

•Directed that the Association conduct annual sessions in the regional area of the MSMA president's residence based on adequate convention facilities.

•Commended the Speaker of the House of Delegates for a report citing the economic benefits of MSMA membership and directed that the report be publicized to the membership.

•Endorsed a program presenting medical socioeconomic topics at annual sessions of the Association and urged state specialty societies to conduct scientific programs concurrently with the annual session.

•Commended an informational program for UMC medical students and residents presented by Dr. Robert E. McAfee, President-elect of the AMA, and urged that a similar program be presented annually.

The Ninety-Second Annual Session of the House of Delegates of the Mississippi State Medical Association

Speaker. Among actions taken by the Delegates were the following:

•Urged all members to participate in and support the Mississippi Physicians Care Network (MPCN) and to urge their local hospitals to do the same.

•Noted the alarming increase in traffic accident deaths and injuries among children and directed that this be conveyed to the public.

•Urged the AMA to study cost, quality and regulatory issues of non-physician health care providers.

•Directed the MSMA Board of Trustees to study and act on recommendations regulating the practice of physician extenders in Mississippi.

•Urged all MSMA members to seek representation of their respective hospital, PHO, HMO or IPA medical staff at semiannual meetings of the AMA Hospital Medical Staff Section.

•Urged that Mississippi become a statewide Medicare fee area and directed the Board of Trustees to obtain support for same from MSMA's component societies as well as state specialty societies in accordance with Medicare guidelines.

•Urged hospital medical staff to adopt stated guidelines for peer review activities.

•Urged the AMA to continue to utilize appropriate public and physician survey data in formulating health policy.

•Urged the MSMA Board of Trustees to study the effect of proposed Medicaid Block Grants on the Mississippi Medicaid Program.

•Directed that MSMA publicize the availability and benefits of local hospice care facilities.

•Urged that all pregnant women be offered HIV testing at the first prenatal visit.

•Urged that all pregnant women be serologically screened for syphilis prenatally and that the newborn infant be tested before hospital discharge.

The Ninety-Third Annual Session of the House of Delegates of the Mississippi State Medical Association met at the Grand Casino Hotel Resort, Biloxi, May 1-5, **1996**, Stanley Hartness, President; H. Vann Craig, Speaker. Delegates elected by MSMA's component societies considered the reports and resolutions. The MSMA House of Delegatestook these actions:

•Noted and commended the growth of the Mississippi Physicians Care Network which during the year had increased its physician network membership by 40 percent, its hospital network membership by 100 percent and had contracted with employer groups totalling over 100,000 covered lives.

•Referred to the Board of Trustees a report requiring a decision on a method to determine physician support for unified MSMA/AMA membership and a vote by the House of Delegates in that regard.

•Increased MSMA dues by $40 to $350 effective with 1997 dues noting that MSMA dues had last been increased in 1993, that general costs of doing business had increased since then, and that average state medical Association dues were currently $399.

•Noted that the Association had successfully supported legislation during the 1996 Regular Session of the Mississippi Legislature which revised education and regulation requirements for physicians' employees taking x-rays, avoided reductions in Medicaid reimbursement for physicians' services, and established a plan to implement medical savings accounts for state employees and teachers.

•Received information on a plan for the Association to determine support for a single Medicare fee area for the state.

•Commended re-establishment of a committee composed of physicians and nurses to study and recommend the status of joint practice arrangements.

•Directed that MSMA provide health insurers in Mississippi with "Guidelines for Prenatal Care" which address hospital stays of mothers and newborns.

•Directed that MSMA furnish component societies with information on AMA membership requirements for medical missionaries and assist them with applications for AMA membership.

•Urged the Mississippi Physicians Care Network to investigate the feasibility of offering a medical savings account product.

•Directed that MSMA support funding during the 1997 Regular Session of the Mississippi Legislature to allow expansion of the State Department of Health's Hepatitis B vaccination program to all children.

•Endorsed regulations of the U.S. Food and Drug Administration restricting access to tobacco products by minors.

•Urged that the MSMA membership be encouraged through the Journal MSMA to report class/ group one communicable diseases to the Mississippi State Department of Health.

•Directed that MSMA support a coalition for a Tobacco-free Mississippi composed of interested organizations and groups.

•Directed that MSMA encourage and support an independent evaluation of the Mississippi Medicaid pilot HMO program.

•Adopted AMA Guidelines for Physician/Physician Assistant Practice.

Conclusion

In rummaging through the annals of the Mississippi State Medical Association one is reminded of the french proverb, "The more things change the more they remain the same." Beginning with the ancestry of the doctors that established the Association...Gamble, Rowland, Whitehead, Ward, Hill, Craft, Caldwell, Crawford, Mitchell, Street, Rush, Wall... the lineage of physicians goes on. Tantamount, membership reports through the years boast of "the largest gain by far in any year in our history;" and today, we're proud to report that the Association's membership is yet at its greatest, 3,196 members in 1996 having grown by 159 new members.

And the issues that concerned the Association's forefathers: the public's health, standards and ethics for medical practice, the physician patient relationship, are all connections between the ancient and the present. Above all, the patient's best interest still comes first.

Karen Evers is director of communications for the Mississippi State Medical Association and managing editor of the JOURNAL MSMA.



Doctors, too, like "Premarin."

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

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Reflections in Time- Quotes from Past Experiences

On House Calls, Measles and Baby-Birthing...

"I remember making my last house call in 1958," said Dr. Mary Ward, a pediatrician in Corinth. "In rural Mississippi, you either went to the patient or the patient came to you. Before my husband and I finished our specialty training we lived in Iuka. I remember many a call at four o'clock in the morning and delivering babies on the mountains of Alabama. We had two children of our own then, a one year-old and a two year-old. If there wasn't a maid around to take care of them we'd have to take them with us to deliver babies," she said.

It wasn't much better when patients came to the house. "They'd come at all hours. One of my boys got a horrible case of the measles from a kid that came to the house for treatment," Dr. Ward said.

"You talk about some sick children," recalls Dr. Ed Moak, a family physician in Richton. "It was a rarity if anyone died from the measles but they were some of the sickest children I've ever seen. Before the vaccine, nothing specific could be done to stop the contagious infection. All you could do was try to keep the child from getting complications like pneumonia."

"I still make house calls," Dr. Moak said. "Some of my patients I've seen for forty years and if I have occasion to I still see them at home," he said. "Sometimes I just go by to see how they're doing."

By 1960 the modern hospital with its fully equipped emergency room had reduced the frequency for making house calls, though they were not obsolete according to Dr. Hardy Woodbridge, a family physician in Jackson. "I had a bag similar to the doctors bag they kept in the early days, with catheters, heart medications, diuretics and so forth. The nurse would keep a list and I'd make two or three on the way home or on my way in," Dr. Woodbridge said.

On Home Deliveries...

"There was one house call I'll never forget," Dr. Winfred Wiser, a Jackson gynecologist/obstetrician remembers. "When I went in, I stepped down onto a dirt floor. The only light was an open bulb hanging from a high tin roof. I could hear the flies make a swarming sound. I looked up and they were covering the ceiling black."

Dr. Wiser recalls early in his career when he was working for a home delivery service in Memphis, "Up until a woman's sixth delivery babies were delivered at home. After six deliveries you went to the emergency room. We'd take a public health nurse, a sterilized pack of instruments and a lot of newspaper on a call. When we arrived, we'd cover the bed with the newspaper to protect it from the blood and amniotic fluid. When the baby was delivered, the mother or grandmother usually took it and the nurse would help clean the baby," he said.

On Administering the Polio Vaccination...

Dr. Woodbridge looks back to the mid-50s when the Salk polio vaccine came to Mississippi, "Two or three of us would get together at select sites in the community on two or three successive Sundays. First we gave the shots, then came the oral vaccine in a dropper," he said.

"We used to put the drops on a sugar cube to give the patient, recalls Dr. Winfred Wiser. "Before the polio vaccine came along, we sent patients to centers with iron lungs. There was one in Tennessee, it had 30 or 40 iron lungs that they would put the patients in. To get out, the patient had to learn how to breathe on their own," Dr.

Wiser said. Needless to say, the mortality rate was high because not everyone with polio was able to get to an iron lung.

Dr. Mary Ward remembers, "Before the polio vaccine there were always big outbreaks of the disease in the summer for some reason. Because of the season, people used to think they acquired polio from swimming," she said.

On Medicare and Medicaid...

Dr. S. Jay McDuffie, a family physician in Nettleton, remembers the 1961 House of Delegates meeting, "It was a full House in support of the Kerr-Mills bill which gave economic help to the needy while at the same time leaving others free to help themselves, reducing the burden on government."

"Initially we were opposed to Medicare and Medicaid" he said. "Dr. E. Vincent Askey, AMA President then, had come from Los Angeles that March to speak before the Homochitto Valley Medical Society and Natchez civic and service clubs, against the King-Anderson bill supported by Kennedy. On behalf of the AMA, he felt massive federal intervention into the medical field was in the wrong direction because it gave to all over 65, regardless of their own obligations of family, shelter, clothing, food and education." Dr. Askey noted in his speech, "Social Security medicine is the stepping stone to full-blown socialized medicine in this country."

"Medicare and Medicaid were the biggest things to happen to the poor people of Mississippi," Dr. McDuffie said. It was a great benefaction to them and the physicians got more pay. While we weren't big on it then; now, none of us could survive without it," he said.

On Medical Schools

One thing different about medical schools now is that female medical students are frequent. "When I graduated from the University of Tennessee School of Medicine in 1949 I was the only female in my class of forty graduates. I met my husband (Dr. Dennis Ward, now a surgeon in Corinth) in medical school," said Dr. Mary Ward. "We met in anatomy lab, working four to a cadaver," she added.

Dr. Ed Moak commented, "I think medical schools are looking more at what the student is going to do and what they need to know to prepare them for their field instead of piling it all on. They're revamping their curriculums to better qualify students," Dr. Moak said.

On Medical Progress

Dr. S. Jay McDuffie was secretary of the Northeast Mississippi Medical Society in 1958 and thinks back: "We had two real good surgeons on staff at Tupelo Medical Center and fifty beds back then. Today, through tremendous growth we have 360 physicians and 700 beds," he said. "I remember having to take prostectomy patients to Memphis to a urologist. We sent patients to Jackson for disk surgery. Now we have all the specialists...rheumatologists, neurologists, cardiologists. Now we do cardiovascular surgery, by-passes, and angioblasts here everyday." Dr. McDuffie said, "The big thing back then was when we transmitted an EKG from Tupelo to Jackson via telephone."

"If I had been told of the changes in surgery by the year 1996 when I came home to Mississippi in 1956 after completing my surgical training, I would have never believed it!" said Dr. Dick Field, Jr., a surgeon in Centreville. "The disease pattern has shown marked change, i.e., we did several thyroids a week, now rarely; many vein stripping, now almost never; and several gastric resections for duodenal ulcer disease per week, now only occasionally. Duodenal ulcer disease is explicable and the same for thyroid surgery, but I'm not certain about varicose veins," he said.

"The technological advances have been incredible. The stapling techniques for gastrointestinal surgery are well proven and make operating timesaving. Even now I marvel at the 16x normal vision magnification in laparoscopic surgery and the outpatient status of most of these cases. The possibility of a ruptured spleen or a tubal pregnancy caused us much concern and observation, whereas now in thirty minutes time, the ct scan and/or ultrasound machines give us an accurate answer. The extensive use of respiratory and physical therapy have greatly enhanced the recovery time of many problems," said Dr. Field.

He added, "Finally, on a negative side is the increased and increasing problem of reimbursements. In 1956, we had no insurance clerks in our clinics, in contrast to their major role now in our work and their importance to us. Then, too, in 1956 we were able to make our own decisions in patient care. But now we must bow to many other demands including insurance companies, administrators, and the overwhelming government presence in our daily work."

When asked which era he prefers?, "Easy," he said. "1956."

If you have recollections relative to advancements in medical practice and would like to submit them, you may send them to ***Karen Evers, Managing Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39296-5229.*** *They may be used in future articles.*

Season's Greetings

from MSMA Alliance Members,

Officers, Board, and Past-Presidents

on behalf of

AMA Education and Research Foundation

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AMA - ERF contributions received for this greeting benefit the medical school of the donor's choice. Contributions designated for the University of Mississippi Medical School provide Summer Research Fellowships and associated activities for medical students.



Fred L. McMillan, M.D.

The President's Page

What I Want for Christmas

Dwalia South suggested this topic to me for the December issue. It sounded great until my past came up. Dad only told me this once; however it has stuck with me ever since, "Why wish for a loaf of bread when you can wish for the grocery store?" He may have meant it in a different context; however, I have always taken it to mean that wishing for something is futile. Instead, want something and then make it happen. That has made it impossible for me to write this article on what I wish we could get in medical reform. So instead, here is my wish list after a reality check.

Patient Protection - Particularly on a national level. This was left out of the last federal legislation; however, the congressional leaders have given us some assurance that we can expect some action on this in the upcoming Congress. In particular, I am talking about not allowing an insurance company to withhold medically necessary treatment from patients or gag physicians from discussing all the options.

Medicare Reform - The Medicare program must be solvent while allowing for future growth rates that cover patient needs. This includes assuring physician payments that will guarantee patient access. At the same time bureaucratic red tape and errors in claim processing must be significantly improved.

Legislative Liability Reform - There is a desperate need for Congress and our legislators to enact meaningful liability reform that insures fair compensation to patients with legitimate claims, while eliminating excessive malpractice awards that lead to defensive medicine.

Hopefully, this year we will be able to enact legislation that will establish some mandatoryoffset so as to reduce the jury awards when duplicate payments for the same loss are involved - the collateral source rule. We also hope to pass a statute of repose with a five year statute of limitations for claims of medical malpractice.

Anti-Trust Relief - On a national level I want legislation enacted that allows physician networks to compete on a level playing field so that patients can choose plans that place their interest first, i.e. physician networks that allow patient choice and use out of network providers at a nonprohibitive cost.

Telemedicine - The State Legislature along with the medical licensing board need to adopt regulations so that physicians within the state can consult with other physicians outside the state; however, physicians who are located outside of Mississippi who are making a diagnosis on a patient or prescribing treatment to a patient need to be required to have a level of licensure within the state that causes them to be accountable to the Medical Licensure Board and that accommodates quality related functions to be performed by them in Mississippi.

Medicaid - The State Legislature needs to enact legislation and the Governor's office needs to implement policies that expands the HealthMacs primary care physician program to all counties not presently participating. The legislature needs to be sure the demonstration project for Medicaid HMO's allows Medicaid to contract with provider service networks (PSNs) and allows Medicaid recipients to choose either HealthMacs or a HMO/PSN product. The legislature also needs to remove the exemption from the Medicaid program regarding compliance with Mississippi's patient protection act. HMO's should be required to annually report to the State the percentage of revenues spent on health care services as well as the amounts on administration.

These are a few things that I want. Now for my wish list (the grocery store). I wish everybody would wear a helmet when riding a bicycle or motorcycle. I wish every child would be properly restrained while in a car and all smokers and other tobacco users would decide that tobacco is harmful to their health and easily quit. I also wish (here comes the warehouse) that violence at home and on the streets becomes a non-issue.

As always, I get something nice for Christmas and some things are left over for me to work toward getting next year.

Merry Christmas to ya'll and all of your family.

Fred

MSMA 129th Annual Session
May 14 - 18, 1997
Grand Casino Hotel
Biloxi, Mississippi
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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVII, NUMBER 12
DECEMBER 1996

We Will Prevail

Just recently the U.S. Federal Trade Commission and Department of Justice released new antitrust enforcement guidelines, and the news this time is better for us. No longer will we have to share risk in the form of capitation or fee withholds in order to form practice networks to compete with large insurers. Physician networks will not be held down as before, and one begins to sense a sea change.

Pick up **Time Magazine**, watch **60 Minutes,** read the **Clarion-Ledger**, and observe the public being made more aware of the abuses of unfettered managed care and HMOs. "Mortality data alone," said the medical director of a Blue Cross affiliate to the **Wall Street Journal**, "is a pretty small factor in determining physician referrals" for heart surgery. People are beginning to cringe, and to react. Many states now are passing laws legislating minimum hospital stays for maternity. More laws will follow, until it may be easier for the nuclear reactor at Grand Gulf to operate under its enormous regulatory burden than for a managed care company to conduct business.

Or, more simply, the doctors can be released to run their own organizations. Doctors, you see, don't have to extract 30% of the premium dollar as insurance companies do in order to make money. We make our money from the fees—no middleman's profit, in other words. A hospital based managed care organization must extract its share, too, so that its large asset base (beds and CT scanners—like old industrial factories) can be funded.

Therefore, we will prevail in the managed care environment. Once we perceive the advantage in releasing some of our precious individual independence to our elected governing boards, and once we figure a way to pay ourselves in a manner that conserves resources, we will again make the health care decisions for society--I'm sure to almost everyone's relief.

-Leslie E. England
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



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Foundation for Medical Care Announces New Projects

Two new projects under development at the Foundation for Medical Care represent different approaches for the Health Care Quality Improvement Program (HCQIP), now in its fourth year under the direction of the Health Care Financing Administration (HCFA).

The program is now allowing opportunities for studies of practice patterns in settings other than the traditional inpatient area. This effort will provide the means to assist providers in other settings to identify opportunities to improve quality of care.

One project will address acute myocardial infarction (AMI) treatment in the emergency room, focusing on the use of thrombolytics and aspirin. Some hospitals were not included in the Cooperative Cardiovascular Project, which has been a national effort, because many small facilities provide evaluation and initial therapy in the emergency room, then transfer the patient to a larger facility for more definitive care. These transfers were not included in the study.

The new project will give collaborating hospitals the opportunity to study their processes and seek improvement in the evaluation and therapy areas prior to transfer. So far a total of 13 hospitals have expressed an interest in participating in the AMI project.

Another new project concerns diabetes, since it represents a prevalent condition for treatment primarily in an outpatient setting. "The Foundation is interested in working with physician offices in evaluating patterns of care for diabetes," said Dr. Alton B. Cobb, clinical coordinator. "We would like to extend the scope of clinical improvement projects which have been hospital-based to physician office practice. This is our first effort to apply the clinical improvement project methods to ambulatory care."

He noted that several peer review organizations have projects underway dealing with the outpatient care of diabetes. The clinical indicators used have been selected from the American Diabetes Association (ADA) Guidelines and generally include glucose control (blood glucose or hemoglobin A 1c measurement), evaluation of foot care, eye examinations, urine screening for micro albuminuria and nutrition education. Much of the opportunity to improve care and outcomes for diabetics is in the area of ambulatory care, he added.

Several groups of physicians have been asked to consider participation and have been mailed draft summaries of the key indicators identified from the ADA Guidelines along with the project protocol utilized in Alabama and several other states.

The procedure will involve abstracting records from several physicians' practices for baseline on these key indicators; analyzing the patterns shown; conducting an educational program on the indicators; and looking again at records in the same clinics to measure practice and process changes in care. The physicians taking part in the project will be volunteers and collaborators.

The Foundation's Analysis and Education Department implements the HCQIP projects.

Fax Available for Certification

A change in the Foundation's Medicaid procedures includes the use of the facsimile system for certification. Any physician who wishes to call from his or her office for purposes of certification may utilize the fax or the telephone method.

The fax number is 354-0996 or 1-800-203-4146.

Telephone numbers are 352-4577 and 1-800-844-0999.

Managed Care Conference Set for February 7

"Shaping the Change—Staying the Course: A Managed Care Conference" is the theme of a Feb. 7 program sponsored by the Mississippi Academy of Family Physicians and the Foundation for Medical Care. The program will be highlighted with special speakers and will feature continuing medical education hours for participants.

The event will take place at the Jim Buck Ross Agriculture Museum in Jackson from 9 a.m. to 4 p.m. A reception commemorating the Foundation's 25th anniversary will conclude the day at the Mississippi Sports Hall of Fame and Museum. Interested physicians are urged to make plans to attend the program and reception.

Registration information is being mailed with complete details; for further information, contact the Academy office at 957-7722 or the Foundation, 354-0304.

-James S. McIlwain, M. D.
Principal Clinical Coordinator

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Physicians' Recognition Award

Four MSMA members were named recipients of the AMA Physicians Recognition Award in October 1996. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

COAST COUNTIES MEDICAL SOCIETY
Rickey Lynn Chance, DO

DELTA MEDICAL SOCIETY
John Phenis Hey, MD

EAST MISSISSIPPI MEDICAL SOCIETY
Donald Wayne Ratliff, MD

NORTHEAST MISSISSIPPI MEDICAL SOCIETY
Eddie Clay Starnes, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**



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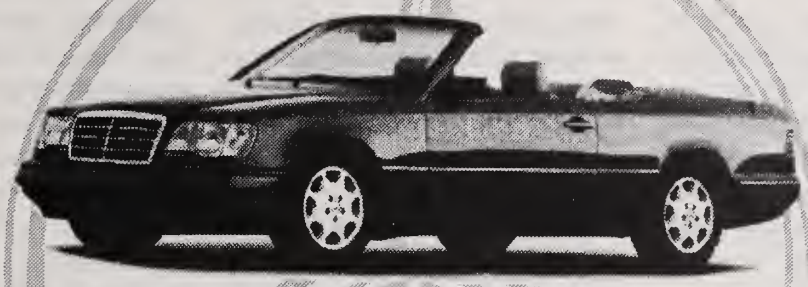
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New Members

ANTHONY, BRIAN T., Bay St. Louis. Born Honolulu, Hawaii, August 29, 1961; MD University of Tennessee College of Medicine, Memphis, TN, 1987; general surgery residency, Louisiana State University Medical Center, 1987-92; elected by Coast Counties Medical Society.

BRUMLEY,MICHAEL ALLEN, Laurel. Born Columbus, MS, October 14, 1957; MD University of Mississippi School of Medicine, Jackson, MD, 1989; pediatric residency, University Medical Center, Jackson, MS, 1989-90; internal medicine residency, Same, 1/91/-12/92; elected by South MS Medical Society.

CURREN , EDWARD L., Laurel. Born Parkersburg , WV, April 15, 1967; MD Northwestern Medical School, Chicago, IL, 1992; interned Loyola University Medical Center, Chicago, IL; ophthalmology residency, University of Tennessee Medical Center, Memphis, TN; elected by South MS Medical Society.

DAVIS-SULLIVAN, HURSIE J, Jackson. Born Hinds Co., June 21, 1962; MD University of Iowa College of Medicine, Iowa City, Iowa 1993; family practice residency, University Medical Center, Jackson, MS, 1993-96; elected by Central Medical Society.

DAVIS, MICHAEL L., Vicksburg. Born Wichita Fall, TX, 1947; MD University of Mississippi School of Medicine, Jackson, MS, 1977; interned one year, University Texas Medical Center, San Antonio, TX; internal medicine residency, University Medical Center, Jackson, MS, 1979-81; nephrology fellowship, Same, 1994-95; elected by West MS Medical Society.

EMIG , ERIC W., Tupelo. Born Mt. Holly, NJ, July 6, 1964; MD Robert Wood Johnson Medical School- Rutgers Medical School, Piscataway, NJ, 1990; radiology residency, Thomas Jefferson University Hospital, Philadelphia, PA, 1991-95; diagnostic radiology fellowship, same, 1995-96; elected by Northeast Medical Society.

FIELD, CYNTHIA O., Jackson. Born Frankfort, Germany, April 26, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1990; pediatric residency, University Medical Center, Jackson, MS, 1990-93; child development fellowship, same, 1994-96; elected by Central Medical Society.

HENDERSON, MURDOC M., Meridian. Born Hattiesburg, MS, October 1, 1953; MD University of Mississippi School of Medicine, Jackson, MS 1983; ob-gyn residency, Fitzsimmons Army Medical Center, Aurora, CO, 1984-87; elected by East MS Medical Society.

MANDYBUR , GEORGE T., Jackson. Born Boston, MA, July 27, 1964; MD University of Cincinnati College of Medicine, Cincinnati, OH, 1990; general surgery, Case Western Reserve University, Cleveland, OH, 7/90 - 6/91; neurosurgery residency, Lomi Linda University Medical Center, Lomi Linda, CA 1991-96; elected by Central Medical Society.

McAFEE, DAVID M., Biloxi. Born May 2, 1962; MD Temple University School of Medicine, Philadelphia, PA, 1988; surgery internship, Easton Hospital, Easton, PA; anesthesiology residency, Rush, Pres. & St. Lukes Medical Center, Chicago, IL 1989-92; elected by Coast Counties Medical Society.

McCULLOUCH, CHARLES LARRY, JR., Philadelphia. Born Louisville, MS, November 7, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; family medicine residency, University of Alabama Medical Center, Huntsville, AL, 1993-96; elected by East MS Medical Society.

NEWLANDS , SHAWN DAVID, Jackson. Born November 27, 1960; MD University of Texas Medical Branch, Galveston, TX, 1990; surgery internship, Virginia Mason Hospital, Seattle, WA, 1990-91; otolaryngology residency, University of Washington Medical Center, Seattle, WA, 1991-95; elected by Central Medical Society.

OLDS, TED WILLIAM, McComb . Born Hibbing , MN, February 21, 1959; MD University of Minnesota School of Medicine, Minneapolis, MN 1986; family practice, one year, University of North Dakota Medical Center, Grand Forks, ND; radiology residency, Oral Roberts University City of Faith Medicine & Research Center, Tulsa, OK, 1988-89; diagnostic residency, University Medical Center, Jackson, MS, 1989-92; elected by South Central Medical Society.

ROSENQUIST, MARY, Gulfport. Born Pasadena, TX, October 6, 1958; DO, Texas College of Osteopathic Medicine, Fort Worth, TX, 1989; family medicine residency, Oklahoma State University Medical Center, 1993-95; elected by Coast Counties Medical Society.

ROTH , RANDY C., Pascagoula. Born New Orleans, LA, March 14, 1966; MD University of Alabama Medical School, Birmingham, AL, 1993; internal medicine residency, Baylor University Medical Center, Houston, TX, 93-96; elected by Singing River Medical Society.

SAULS, DAVID J., Gulfport. Born Gulfport, MS, February 19, 1960; MD University of Mississippi School o f Medicine, Jackson, MS, 1991; psychiatry residency, Washington University-Barnes Hospital, St. Louis, MO, 1991-94; child & adolescent psychiatry fellowship, same, 1994-96; elected by Coast Counties Medical Society.

SMITH, MARY GAIL, Jackson. Born Arcola, MS, May 1, 1955; MD University of Mississippi School of Medicine, Jackson, MS, 1981; pediatric residency, Blank Children's Hospital, Des Moines, IO, 1981- 84; pediatric hematology/ oncology fellowship, Baylor College of Medicine Medical Center, Houston, TX, 1989-92; elected by Central Medical Society.

STANBACK , JOHN EDWARD, Winona . Born Columbus, MS, November 17, 1965; MD University of Mississippi School of Medicine, Jackson, MS 1993; family medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by North Central Medical Society.

STOREY, TROY F., Gulfport. Born August 23, 1967; MD Vanderbilt University School of Medicine, Nashville, TN, 1987; diagnostic radiology residency, Medical College of Virginia Medical Center, Richmond, VA, 1988-91; elected by Coast Counties Medical Society.

TARQUINIO, THOM A., Jackson. Born Barre , VT, July 18, 1947; MD Ohio State University College of Medicine, Columbus, OH, 1973; interned and orthopedic surgery residency, Naval Regional Medical Center, San Diego, CA 1973-78; elected by Central Medical Society.

WOOTEN , WILLIAM H., Vicksburg. Born April 5, 1966; MD University Of Mississippi School of Medicine, Jackson, MS, 1993; interned one year, Methodist Hospital, Memphis, TN; internal medicine residency, University Medical Center, Jackson, MS, 1991-93; elected by West MS Medical Society.

WRIGHT, JAMES TURNER, Greenville. Born Houston, TX, September 20, 1963; MD University of Texas-Southwestern Medical School, Dallas, TX, 1990; otolaryngology residency, Duke University Medical Center, Durham, NC, 92-96; elected by Delta Medical Society.

DEATHS:

COOK, JAMES C., Oxford. Born Detroit MI, January 28, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1990; interned one year, University Medical Center, Jackson, MS; anesthesiology residency University of Florida College of Medicine, Gainesville, FL, 1986-89; died November 15, 1996, age 37.

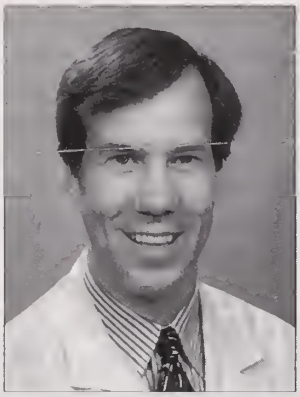
KELLUM , HERMAN E., JR., Vicksburg. Born August 14, 1924; MD Tulane University School of Medicine, New Orleans, LA, 1952; general surgery & thoracic surgery, Charity Hospital of LA, New Orleans, LA, 53-58; died September 9, 1996, age 72.

PACKER, JAMES M., Jackson. Born May 21, 1917; MD Tulane School of Medicine, New Orleans, LA, interned one year Charity Hospital, New Orleans, LA; radiology residency, Charity Hospital & Tulane University Medical Center, New Orleans, LA, 1945-47; died October 19, 1996, age 79.

RICHARDSON, DAVID D., Louisville. Born Louisville, MS, September 6, 1921; MD Tulane School of Medicine, New Orleans, LA, 1953; interned one year The McLeod Infirmary, Florence, SC; died October 9, 1996, age 75.

WALLER , JOHN WILLIAM, Monticello. Born Silver Creek, MS, August 24, 1921; MD University of Tennessee College of Medicine, Memphis, TN, 1948; interned one year, Knoxville General Hospital, Knoxville, TN; died October 1996.

WOLFE, MARION J., SR., Bay St. Louis. Born New Orleans, LA., April 5, 1906; MD Tulane University School of Medicine, New Orleans, LA, 1932; interned one year, Charity Hospital, New Orleans, LA; died September 29, 1996, age 90.



Jim Fuller, MD (above), a second-year resident in internal medicine, has been appointed to serve a two-year term on the Board of Directors for the AMA Political Action Committee (AMPAC). He was recently elected to serve as an alternate delegate to the AMA by MSMA. He is the first resident physician to serve in this capacity.
Candace Keller, MD (below) was also appointed to serve a two-year term on the Board of Directors of AMPAC.



Ralph Vance, MD has been selected to be included in the first edition of Who's Who in Medicine and Healthcare.

J. Edward Hill, MD of Tupelo has been appointed chair of an AMA Task Force which will study and recommend changes in the Medicaid Program. The study will serve as a basis for the AMA's recommendations to the 105th Congress convening in January, 1997. It will address, among other matters, financing of long-term care and access and level of services to low-income children, the elderly and disabled. Both the future of Medicaid and Medicare are expected to be critical issues before the new Congress. Dr. Hill also recently addressed the physicians and staff of the Delta Regional Medical Center in Greenville.

Michael L. Brumley, MD, cardiologist, has associated with **Stevan A. Webster, MD, FACC** of the Heart Clinic in Laurel.

Prentice J. Walker, MD has joined the staff of Lumberton's Family Health Services Clinic.

John Mitchell, MD and **Steve Montgomery, MD** of the Pontotoc Family Medical Clinic recently donated their time to participate in a first annual Sports Physical Screening.

C. Ron Cannon, MD presented a paper and instruction course at the 100th meeting of the American Academy of Otolaryngology-Head and Neck Surgery in Washington, D.C. Dr. Cannon is serving as president of the Mississippi/Louisiana O&O Society this year.

Larry D. Field, MD of Mississippi Sports Medicine Orthopaedic Center recently served as a guest speaker at the Eastern Orthopaedic Association meeting in Hilton Head, SC. Dr. Field presented a talk entitled "Elbow Fractures and the Stiff Elbow."

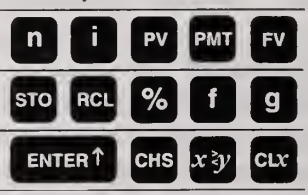
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The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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We offer more than an insurance policy. MPIC is the host of yearly regional workers' compensation seminars. These seminars are designed to inform you of your rights and responsibilities under the Workers' Compensation Act. Loss control consultants are also available for individual on-site visits. MPIC utilizes an active claims investigation staff. Fraudulent claims have been one of the highest costs in workers' compensation. When a claim appears questionable we find out the facts.

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OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JANUARY 1997

SCIENTIFIC ARTICLES

Survival of Carcinoma of the Prostate in Patients Less Than 55 Years Old Compared to Older Patient Groups

Clinicopathologic Conference XV

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What's Happening at the Med School

EDITORIAL

Ecological Disasters

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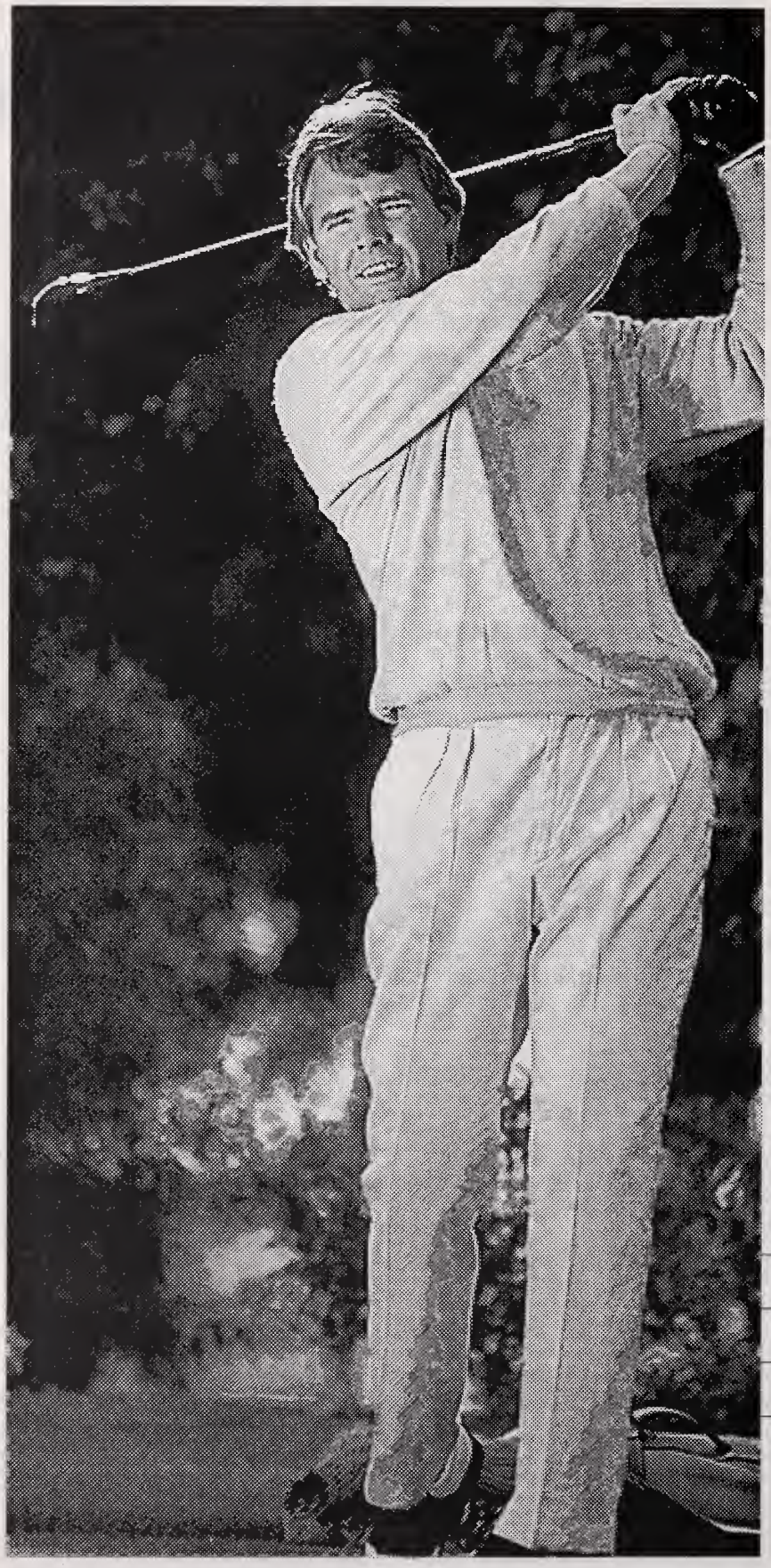
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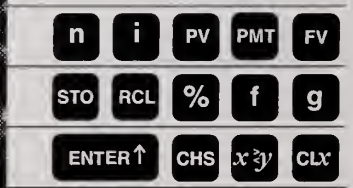
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Survival of Carcinoma of the Prostate Patients Less Than 55 Years Old Compared to Older Patient Groups

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Abstract

Both incidence and death rate from cancer of prostate are rising. Prostate cancer is the most common malignancy in man and second most common cause of death in men. Lung cancer is the leading cause of death in men.

Carcinoma of prostate is generally a disease of older men. Carcinoma of prostate can also occur in the middle-aged men. This study was performed to find whether the middle-aged men survived longer than older men when both groups of patients were compared according to equivalent stage of the disease. In this series, survival is slightly better in younger age groups when patients of all stages are pooled together. Due to small number of patients in younger age groups, survival difference cannot be calculated for each stage of the disease.

Key words- Prostate, SEER

Introduction

Carcinoma of the prostate is the most common malignancy found in men. The incidence of prostate carcinoma has surpassed lung cancer and is the second leading cause of death after lung cancer. In 1995, 244,000 new cases of carcinoma of the prostate will be diagnosed compared to 169,900 cases of lung cancer in men. Prostate cancer will be the cause of death in 40,400 patients in 1995. Lung carcinoma will be responsible for death in 99,470 male patients in 1995.[1] The age specific mortality rate of carcinoma prostate has been increasing steadily in the last 30 years.[2]

Carcinoma of the prostate mainly occurs in older men. The median age of 14,687 patients diagnosed in 1984 was 72.3 years. Only 7.1 % of patients were below the age of 60 years.[3] There is 40 (forty) fold increase in incidence of prostate cancer between the ages of 50 to 85 years.[2] The purpose of this study was to find out if younger groups of men, i.e., below the age of 54 years, survive longer when compared to older groups of patients.

Materials & Methods

All of the patients diagnosed with carcinoma of prostate in the tumor registry of the University of Mississippi Medical Center were reviewed. Patients were divided into two age groups: (a) patients aged 54 years or younger, and (b) patients above the age of 55 years.

There were 623 men diagnosed with prostate carcinoma between 1977 and 1989 who had a median age of

71.5 years. Five hundred and ninety-seven men were aged 55 and older and 26 men aged 54 and under were diagnosed during this period.

Age & Race

The age and race distribution of the younger patients are shown in Table 1. The mean age of younger white patients was 51.7 years. The mean age for younger Afro-American patients were 50.1 years. There was no statistical difference between white and black groups regarding the median age when disease was diagnosed.

The distributions of races were equal in younger aged groups. Young white patients represented 46.15% of the total patient population, and Afro-American patients represented 50% of the younger patient population.

Distribution of the older patients' ages and race are shown in Table 2. In this study, prostate carcinoma was the most common in the group aged 65 to 74 years with a median age of 71.5 years. The second most common group was the 75 to 84 years old age group. Afro-American patients constituted 60% of cases in this series. This reflects the nature of patients referred to our institution. This is a sharp contrast to the study performed by the American College of Surgeons where 85.5% of patients were white. Afro-American patients constituted only 9.4% of total patients.

Staging

All of the patients were staged according to Surveillance, Epistemology and End Results (SEER) program of the National Cancer Institute. Details of SEER staging is shown in Table 3.

Distribution of younger patients according to SEER and TNM'S stage is shown in Table 4. Out of a patient population of 26, eight (30.77%) patients had localized disease.

Distribution of the older patients was done according to the SEER stage as shown in Table 5. From a total of 597 patients, 254 older patients (42.54%) had localized disease. There were very little differences in the rates of localized disease and distant metastasis between younger and older patients. In the National Cancer Data Base (NCDB) survey of 1993, 43.5% of Afro-Americans had localized prostate cancer, compared to 44% of low income whites and 50.4% of higher income men.[13]

Treatment

Six patients were treated with radical surgery alone. Table 6 demonstrates the treatment modalities used. Radical surgery alone was the most common method of treatment in this group of patients. Two patients had

Table 1 — Age & race distribution of younger patients

Age	White	Black	Mexican	Total	%
45	0	1	0	1	3.85
46	1	2	0	3	11.54
48	1		0	2	7.69
49	1	3	0	4	15.38
50	1	0		1	3.85
51	0		1		3.85
52	1		0	2	7.69
53	2		0	4	15.38
54	5	3	0	8	30.77
	12	13	1	26	100.00

Table - 2 Age & Race distribution in older patients

Age	White	Black	Total	%
55-64	67	76	143	23.95
65-74	102	136	238	39.87
75-84	81	120	181	30.32
85-94	4	29	33	5.53
95-104	0	2		0.34
	234	363	597	100.00

Table - 3 Staging according to SEER

In Situ: Noninvasive prostate cancer

Localized -

L1 - Invasive cancer confined to prostatic capsule (intra-capsular)

L2 - Invasion of prostatic capsule

L3 - Prostatic urethra involved

Lx - Localized, NOS (not otherwise stated)

Regional -- (a) Direct Extension to organs

R1 - Periprostatic tissues, seminal vesicle(s)

R2 - Through prostatic capsule, including "fixation"

R3 - Rectovesical (Denonvillier's) fascia bladder, rectum, extraprostatic urethra (membranous urethra)

Regional -- (b) Extension to following Lymph Nodes--

Hypogastric, Illac (common, internal, external), obturator, periprostatic/pelvic, NOS, sacral (lateral sacral, sacral, promontory, presacral)

Distant -- (a) Direct extension or metastasis

D1 - Skeletal muscles: levator ani, pelvic bone, pelvic wall, ureter, sigmoid colon, penis

D2 - "Frozen pelvis"

D3 - Other distant involvement

Distant - (b) to following lymph Nodes-- Aortic (para-aortic, periaortic, lumbar), inguinal, other distant node

Table -- 4 SEER staging of younger patients

SEER Stage	# Patients
Local	8
Regional, NOS	0
Regional Direct Extension	4
Regional Nodes	1
Regional Nodes/Extension	2
Distant	10
Unknown	1
Total	26

Table - 5 SEER staging of older patients

SEER Stage	# Patients
Local	254
Regional, NOS	5
Regional Direct Extension	69
Regional Nodes	14
Regional Nodes Extension	13
Distant	221
Unknown	23
Total	597

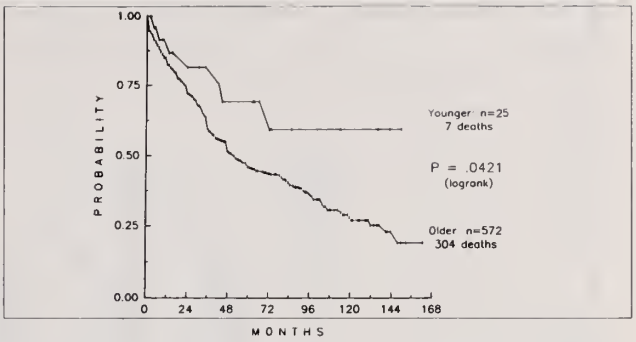


Table -- 6 Treatment of younger patients

Primary Treatment	# Patients
No Treatment	1
Surgery Only	11
Surgery/Radiotherapy	2
Surgery/Chemotherapy	1
Surgery/Hormone	1
Refused Surgery	2
Radiotherapy Only	3
Radiotherapy/Chemotherapy	0
Radiotherapy/Hormone	0
Chemotherapy Only	1
Chemotherapy/Hormone	1
Hormone Only	2
Surgery/Radiotherapy/Hormone	1
Total	26

Table - 7
Details of patients younger than 55 years

Name	Age	Stage	Treatment	Followup in Months	Patient Status
MA	52	II	TURP + Horm	2	D-N
JLB	54	I	TURP	74	D-U
MB	54	III	Surgery	197	A-N
WCB	48	IV	Chemo	19	D-C
JCD	53	IV	Chemo+Horm	91	D-U
WBE	45	?	Surgery	48	D-C
LEE	49	?	Surgery	9	A-C
CLE	54	IV	Oroh.	7	D-C
LF	48	II	Surgery	95	A-N
WEG	49	II	XRT	144	A-U
CHG	54	?	Surgery+XRT	64	D-U
WDH	50	IV	XRT+Horm	24	A-C
WH	49	IV	Horm	70	D-C
FL	49	II	Surgery	162	D-U
GLL	54	IV	Horm	4	D-C
WEM	52	IV	Oroh	24	D-C
LM	46	III	TURP	10	D-C
AHM	53	II	XRT	66	D-U
JM	54	IV	TURP+Orch	5	A-C
CM	54	I	Surgery	15	A-N
WKR	54	II	Surgery	46	A-N
GRS	51	I	No treatment	10	A-N
BS	53	III	Surgery	68	A-N
BCS	53	IV	Oroh+Chemo	45	D-C
JGS	46	IV	TURP+XRT	73	D-C
JTW	48	II	XRT	115	A-N

***** A - N = Alive with No Cancer
A - U= Alive, Unknown
A - C = Alive with Cancer
D - N = Dead with No Cancer
D - U = Dead, Unknown
D - C = Dead with Cancer
XRT = Radiotherapy
Chemo= Chemotherapy
Surgery= Prostatectomy with pelvic node dissection
Horm = Hormone Therapy
Oroh = Orchiectomy
TURP = Transurethral Resection of Prostate

TURP alone and another three patients had TURP with other type of treatments. Three patients were treated with radiotherapy only. Two patients were treated with hormone therapy only. Treatment of other patients were performed by various means depending on the preference of the primary physician.

Survival

The follow-up period is between 2.5 years and 14 years. Life table (Kaplan-Meier) analysis suggests differences in survival between younger and older patients ($p=.0421$) whenever patients of varying disease stages are pooled together. This result is also observed via proportional hazards (Cox) modeling, whereby significance is attained when considering age group alone ($p=.0489$), and marginally ($p=.0611$) for the model containing both age groups and stages together. Figure 1 shows the difference between the survival of young and old patients. However, due to the small number of younger aged patients, it is not possible to verify the survival differences for each stage statistically. One patient was lost to follow-up and was not included in the study. Table 7 gives details of treatment and survival.

Discussion

The incidence of carcinoma of the prostate is rising and more people will suffer from prostate cancer due to increasing life expectancy prostate. Carter & Coffey predicted that during the period of 1980 to 2000 there will be a 90% increase in the incidence of prostate cancer and a 37% increase in the death rate from prostate cancer.[2]

In younger people less than 50 years of age, carcinoma of the prostate constitutes 0.8% to 1.1 % of all patients with prostate cancer.[4] Generally, Younger patients with malignant tumors usually survive longer than older patients. In low grade astrocytoma[5,6] and Hodgkin's[7,8] disease younger patients survive longer. The issue is not clear in patients with carcinoma of the prostate. For a long time, epidemiologists have tried to correlate a patient's age with the prognosis of prostate cancer without success. To make the matters more complicated, carcinoma of the

prostate has a low ratio of clinical disease incidence (0.08% per year) compared to a high prevalence rate of unsuspected cancer (approximately 30%) as found in autopsy studies.[9] Dr. W.F. Whitmore very eloquently expressed the problem of treating carcinoma patients. He stated that cure may not, be necessary in those for whom it is possible and cure may not be possible in those for whom it may be[10] necessary.

The following authors found that younger patients have poorer survival than older patients. Rosenberg studied 500 consecutive autopsy reports of patients who died of carcinoma of the prostate. He concluded that the younger the patient, the more virulent is the tumor.

Johnson[12] reviewed the data of carcinoma of the prostate patients treated from 1954-1969. Twenty-six patients were below the age of 50 years. The five year and ten year survival rates were 14.3% and 7.2% respectively. In the older group of patients, the five year and ten year survival rates were 43.0% and 25.3%. Johnson found only 2 of 26 patients were suitable for radical prostaiectomy. Tjaden[13] and Associates found only 12% of their patients suitable for radical prostatectomy. In his series, younger men had poorer survival compared to older people.

The other authors disagree with the above conclusion. They reported in their series the opposite findings. These authors concluded that younger patients survive longer than older patients. Huben[14] reviewed data from the American College of Surgeons and compared the clinical features and survival of patients younger than 50 years with that of patients older than age 50. Younger patients were diagnosed by needle biopsy of the prostate, whereas older patients were diagnosed by TURP. In the younger group, there were more Stage D patients and less number of Stage A patients. Statistically, there was a better survival in Stage B younger patients. The survival rate at five years was 83.8% in men less than 50 years compared to 68% for men aged over 50 years, ($P > 0.001$). The ten-year survival was 70% in the younger age group compared to 48% in older age group of patients. Cochran and Kadeskyl[5] reviewed private practice experience in treating carcinoma of the prostate. The authors found a sharp increase in the number of men less than age 50 with a diagnosis of prostate carcinoma. The incidence rate for younger men was 4% compared to the national figure of 1 %. The survival was 90%. The authors attribute this phenomenon due to the biopsy of small "unimportant nodules". Byar and Mostofi[16] reviewed the cases in Prostatic Tumor Registry at AFIP from 1945-63. Forty-seven patients were 50 year s old or less. This group was compared to 210 patients who were older than 50 years with a mean age of 69 years. The five year survival rate was 86% for younger patients compared to 63% in the older patients. The authors concluded that survival of younger men is not worse when compared to the older group of patients, and it may be even better. Byar and Mastofa, postulated that death from a prostatic cancer in a young man makes much more lasting impression on the physician than the death from a prostatic cancer in an older man. This probably gives the illusion that the disease is more lethal in younger people.

In our series reported here, there are differences in survival between the two groups of patients, when varying disease stages are pooled together. Specifically, at three year points, these proportions were 0.81 and 0.60, respectively ($p < 0.01$). Due to a small number of patients in the younger aged group, it is not possible to perform statistical calculations to compare survival of each group stage by stage.

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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XIV

Selection and Preparation:
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Differential Findings: Margaret E. Miller, M.D.
Radiological Findings: Ajay Malpani, M.D.
Pathological Findings: Cynthia Lynch, M.D.

CASE PRESENTATION

In summary, the patient is a 74-year-old male with hypertension, chronic dementia and hearing loss, all of which are longstanding. He has no history of fever, chills, nausea, vomiting, weight loss, or change in appetite. He denies cough, shortness of breath or hematemesis, night sweats, melena, or change in bowel or bladder habits. No history was given of seizures, falls, or trauma. He does not drink alcohol and does not have access to other drugs or chemicals. He has not travelled in the recent past.

Past history is negative for cancer, tuberculosis, or pneumonia. Family history is remarkable for hypertension. He is currently a non-smoker, but it is unclear whether he smoked in the past. Occupational exposure history is not available. Medications include nifedipine 10 mg t.i.d. He does not take diuretics, ACE inhibitors, beta blockers, digoxin or lithium.

Physical exam was unremarkable except for hypertension, hearing loss, and left chest wall tenderness. There were no signs of bruising, rash, or other skin lesion. He appeared to be thin.

Admission laboratory included a white count of 6,600 with a normal differential, a hemoglobin of 9.5, a hematocrit of 28.2, and a platelet count of 167,000. The MCV was 90.6, the RDW was 14.4, the PT and PTT were 11.5 and 24. Sodium was 135, potassium was 5.3, chloride was 110, bicarb was 25, BUN was 53, creatinine was 2.8, and glucose was 129. The calcium was 9.5, magnesium was 2.0, phosphate was 3.0, alk phos was 144, GOT was 17, total bilirubin was 0.6, total protein was 6.7, and the albumin was 4.0. His urinalysis revealed specific gravity of 1.015, pH of 5.0 with a trace of protein and blood, and 1-3 white cells/high power field.

A chest x-ray done revealed an abnormal soft tissue density at the left mid and upper lung fields. Destruction of the left fifth rib with elevation of the left hemidiaphragm and diffuse osteopenia with evidence of a prior rib fracture on the right was noted.

The patient was admitted to the Psychiatry service for evaluation of dementia and eventual nursing home placement. Internal Medicine was consulted for evaluation of the patient's abnormal chest x-ray, and he was transferred to the medicine service for further workup. A CT scan of the chest without contrast was obtained which revealed a pleural based soft tissue mass with a lytic process involving a long segment of the left fifth rib posteriorly and laterally. Marked generalized osteopenia was also noted.

Dr. Miller: Focusing on chest wall tenderness, several possible diagnoses come to mind. Early herpes zoster which has not yet erupted into a rash could cause several days of tenderness and pain with no obvious lesion. An inflammatory condition, such as rheumatoid arthritis or ankylosing spondylitis, can manifest as tenderness at tendon insertion sites along the rib. This is unlikely, as he has no other manifestations of RA or ankylosing spondylitis. Perhaps his dementia prevented him from remembering a recent fall resulting in a rib fracture. A forceful cough in an elderly person with osteoporosis could result in a fracture.

Malignancy is certainly high on the differential in a 74-year-old. The chest radiograph and CT scan reports confirm a chest wall mass involving bone, pleural space, and lung tissue. These findings significantly narrow the differential to processes involving these compartments. Malignancy is the most likely etiology, followed by an infectious process. Less likely causes of chest wall mass will also be discussed. Malignancy may have arisen in the lung, pleura, or rib with secondary involvement of the other structures.

Primary lung malignancies can involve bone by contiguous spread. Squamous cell carcinoma is more common in smokers and typically presents with a more central lesion. This presentation is more typical of adenocarcinoma or large cell lung cancer, both of which can present as a peripheral mass with lytic bone lesions. Bronchioalveolar carcinoma usually does not cross tissue planes. Small cell lung cancer rarely presents as a peripheral mass without mediastinal or hilar involvement. An aggressive bronchial carcinoid could present as a peripheral lung mass, and one would not expect symptoms of carcinoid syndrome unless the patient had liver metastases.

Non-Hodgkin's lymphoma can present as a discreet lung mass without hilar involvement. A few sarcomas

can present with a bulky lung mass. Pulmonary blastoma arises from mesoderm and may occur as a peripheral lung mass. Multiple myeloma occasionally arises in the lung tissue, but isolated plasmacytoma usually occurs in the upper airway.

Metastatic disease must be considered. Colon cancer, renal cell carcinoma, sarcoma, and melanoma may metastasize as solitary pulmonary nodules. Breast cancer is very unlikely in a male, and cancer of the cervix will not be considered. Lung metastases are often peripheral but are rarely invasive to contiguous bone and other tissues. Nodules are usually multiple.

The next compartment to consider is the pleura itself. Malignant mesothelioma is usually associated with other symptoms such as chest pain and shortness of breath. The tumor is diffuse, encasing the lung. The patient gives no history of asbestos exposure. Pleural-based lymphoma usually has an associated Pleural-based lymphoma usually has an associated pleural effusion. Soft tissue sarcoma or pleural metastatic disease must also be considered.

The boney involvement revealed by CT scan favors a diagnosis of primary bone neoplasm, with multiple myeloma being the most common in this age group. Osteosarcoma usually presents in younger patients, but persons in the fifth and sixth decades who have prior radiation exposure or Paget's disease can develop osteosarcoma. Lymphoma may arise in bone but is typically associated with osteoblastic changes. Occasionally, lymphoma of bone may present with osteolytic changes not unlike those seen in Ewing's sarcoma, giant cell tumor, and malignant fibrous histiocytoma.

Metastatic bone disease from a distant primary is a consideration, but this is less likely than primary neoplasm. Breast cancer is unlikely. Lung cancer, especially squamous cell carcinoma, may present as a purely lytic bone lesion. Adenocarcinoma with a small lung primary could present with a bone metastasis. Of the tumors arising in the genitourinary tract, prostate cancer is the most common in this age group. The bone changes associated with prostate cancer are typically sclerotic, not lytic. The patient does have renal insufficiency consistent with obstructive uropathy, as well as red cells in his urine. Renal cell carcinoma sometimes presents with metastatic disease. Finally, thyroid cancer may present as an expanding lytic bone lesion, but the patient is without a neck mass or mediastinal involvement.

Infectious processes may cause a lytic bone lesion, and chest wall mass and are included in the differential. Blastomycosis is not uncommon in the Mississippi River Valley and can affect an immunocompetent host. Bone lesions may be associated with granulomatous changes in surrounding tissues, resembling malignancy. Coccidioidomycosis may produce a similar lesion, but it is not found in Mississippi. Histoplasmosis and cryptococcosis are far less common in an immunocompetent host. Among bacterial pathogens, actinomycosis could present in this manner, with 15-30% presenting with a thoracic focus. The infection begins in the lung and can involve pleura and chest wall, with granulomatous changes and fibrosis. Nocardia infection manifests as a lung primary 75% of the time, but the lesion is typically necrotic with cavity formation and air-fluid levels on radiograph. Mycobacteria may cause a mass lesion. Bone infection more commonly involves the spine, and pleural involvement usually results in a pleural effusion.

Although very unlikely in this case, Echinococcosis could produce a similar chest wall lesion. In bone and in lung, an Echinococcal cyst can be very aggressive and invasive if it is without a capsule. Lung lesions are usually peripheral with an inflammatory reaction.

This patient gave no history of fever, and he did not have elevated white blood count, facts that argue against infection as the cause of his chest wall mass.

Eosinophilic granuloma can present as a single lytic bone lesion, usually in the rib in adults, and it may involve the lung. Fibrous histiocytoma and plasma cell granuloma should be considered. He is without multisystem involvement and has no signs of Wegener's granulomatosis, making it unlikely. Sarcoidosis is unlikely in a patient with no lymphadenopathy.

Osteopenia was another noted radiographic finding. The list of causes of osteopenia is extensive. Most involve high bone-turnover which is associated with an elevated alkaline phosphatase level. Those conditions associated with low bone turnover include senile osteoporosis, multiple myeloma with its increased osteoclast activity, and chronic acidemia.

The laboratory data provided include Potassium of 5.3. There is no history of drug therapy with spironolactone, captopril, heparin, beta blockers, succinylcholine, digoxin, or arginine. Hyporeninemic hypoaldosteronism, also associated with high chloride and potassium, is a possibility. Acidosis is associated with transmembrane shift of potassium. Increased cell turnover or destruction, as in tumor lysis syndrome, crush injury, or rhabdomyolysis, causes elevated potassium. Hyperkalemic periodic paralysis is unlikely, as the patient and his brother did not reflect this in the history. He is not diabetic.

Pseudohyperkalemia must be mentioned. Prolonged tourniquet administration, a hemolyzed blood specimen, thrombocytosis or leukocytosis are other causes of 5.3

potassium. Chloride level is 110, often associated with metabolic acidosis with bicarbonate depletion. There is no history of diarrhea or laxative abuse. Contraction alkalosis is a possibility. Renal tubular disease is a strong possibility, particularly in light of his elevated BUN/Cr. Respiratory alkalosis is a less likely cause of his hyperchloremia, as there is no mention of hyperventilation. No exposure history to ammonium chloride, IV saline, steroids, or salicylate was given.

Anion gap is 4, which narrows the differential considerably to conditions involving a fall in unmeasured anions, such as hypoalbuminemia, or a rise in unmeasured cations, as in hyperkalemia, hypercalcemia, hypermagnesemia, lithium intoxication, or increased proteins.

Paraproteinemia caused by multiple myeloma or another lymphoproliferative disorder or a polyclonal gammopathy as is seen in liver disease could explain the low anion gap. Hyperlipidemia may obscure an elevated serum sodium, resulting in laboratory artifact. Bromide ingestion and the use of TRIS buffer can cause falsely elevated chloride level.

Probable Diagnosis: ***Multiple myeloma, light chains disease***

His age and history of indolent onset of disease are consistent with multiple myeloma. Lytic bone lesions typically involve red marrow as is found in ribs, sternum, vertebrae, skull, and pelvic girdle. Osteopenia is common. The turnover of bone is low, resulting in low alkaline phosphatase. Osteoclast activating factor produced by the malignant clone of plasma cells results in reduced osteoblastic activity. Bone disease in multiple myeloma usually manifests as bone pain, pathologic fractures, hypercalcemia in 30% of patients, hypercalciuria, and reduced anion gap.

At presentation, 80% of myeloma patients have elevated globulins, which may result in hyperviscosity syndrome, bleeding diathesis, or cryoglobulinemia. This patient probably falls into the light chains disease category, which is not associated with elevated total protein or hyperviscosity.

Renal impairment is found in 30% of patients at diagnosis, but many more patients develop this during the course of disease. The mechanisms include myeloma cast nephropathy or myeloma kidney, amyloidosis, or light chain deposition disease. This patient's low anion gap cannot be explained by paraproteinemia but may be explained in part by type 4 renal tubular acidosis resulting in hyperchloremic metabolic acidosis with elevated potassium. He has acidic urine (pH 5) consistent with type 4 RTA.

Diagnostic Procedures: Biopsy of the chest wall mass. I expect to find plasma cells, either from plasmacytoma or reactive plasmacytosis. Serum and urine protein electrophoresis should reveal Bence-Jones proteinuria in this patient. Finally, a bone marrow aspirate would be helpful to look for plasmacytosis.

Dr. Malpani: The chest radiograph (Figure 1) and the chest CT (Figure 2) demonstrate a large expansile lesion involving the left fifth rib posteriorly. There is an associated soft tissue component which is causing a band like opacity in the left mid lung on the chest radiograph. On Figures 3 and 4, lytic lesions are seen in the right humerus and femur. Axial skeleton radiographs (not shown) demonstrated generalized osteoporosis with collapse of several vertebral bodies. The whole body bone



Figure 1 (above) and 2 (below): *Chest radiograph and chest CT demonstrate a large expansile lesion involving the left fifth rib posteriorly. There is an associated soft tissue component which is causing a band like opacity in the left mid lung on the chest radiograph.*

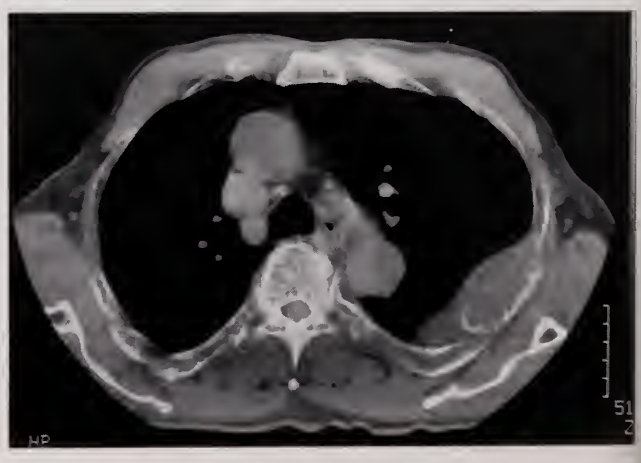






Figure 3 (left) and 4 (right): *Lytic lesions are seen in the right humerus and femur. Axial skeleton radiographs (not shown) demonstrated generalized osteoporosis with collapse of several vertebral bodies.*

scan (Figure 5) demonstrates focal areas of increased uptake in a few ribs. No uptake is seen in the left fifth rib or in the right humerus and femur. The number of lesions seen on the radionuclide bone scan are far fewer than those seen on the radiographic body survey.

Differential possibilities on the basis of the above findings would include multiple myeloma and metastatic bone disease. The presence of generalized osteoporosis and relative lack of uptake of the radionuclide bone tracer with demonstration of many more lesions on the whole body radiographic survey favors the diagnosis of multiple myeloma.

Dr. Lynch: A fine needle aspiration was done of the rib and soft tissue mass with CT guidance. Here is a panoramic view of one of the fine needle aspirate smear and you can see it is a very cellular smear. In addition to that, you can appreciate that the cells are singularly spaced. There are no big sheets of cells. These are all single cells. When we do a fine needle aspirate, anything that clots in the syringe or is left over in the syringe after making smears, we make a "cell block" out of it. We process it as if it is a piece of tissue. We had a generous cell block in this case. The sectioned tissue revealed a small amount of bone marrow within the clotted blood. There are sheets and sheets of a very monotonous cell population. You don't see megakaryocytes or islands of erythrocyte precursors; it's just a monotonous infiltrate. These appear to be plasma cells. On a thinner area of the smear stained with hematoxylin and eosin, you can see the characteristic cartwheel nucleus that is eccentrically placed. Since I had a hint of the diagnosis, I did a Wright-Giemsa stain as if the specimen was a bone marrow smear or a peripheral blood smear. You can appreciate the cytologic features of the plasma cells better with this stain. Here again is a cluster of plasma cells, which is what was basically in all the smears. The pleural based mass that was expanding outside of the rib was a plasmacytoma or a focus of multiple myeloma.

Differential diagnosis: ***multiple myeloma with a plasmacytoma of the lung.***

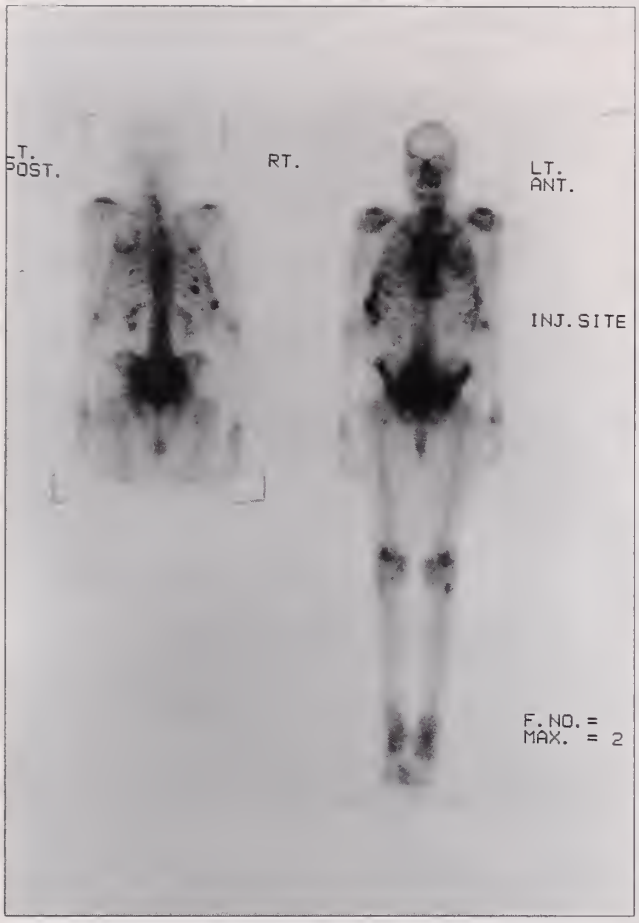


Figure 5: *Whole body bone scan demonstrates focal areas of increased uptake in a few ribs. No uptake is seen in the left, fifth rib or in the right humerus and femur. The number of lesions seen on the radionuclide bone scan are far fewer than those seen on the radiographic body survey.*

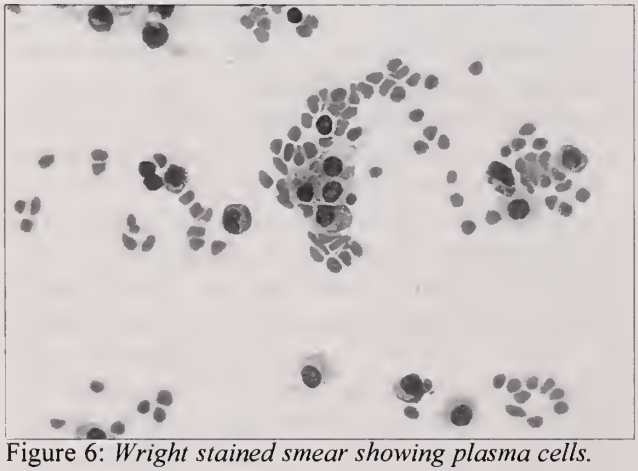


Figure 6: *Wright stained smear showing plasma cells.*

***Dr. Files** is Professor of Medicine and Associate Chairman for Clinical Affairs, Department of Medicine. **Dr. Miller** is Assistant Professor of Medicine; **Dr. Malpani** is Staff Radiologist at the VA Medical Center; and **Dr. Lynch** is Chief Anatomic Pathologist at the VA Medical Center. **Drs. Guynes, Huey,** and **McMullan** were Chief Medicine Residents in the Department of Medicine at the University Medical Center, 1994-1995.*

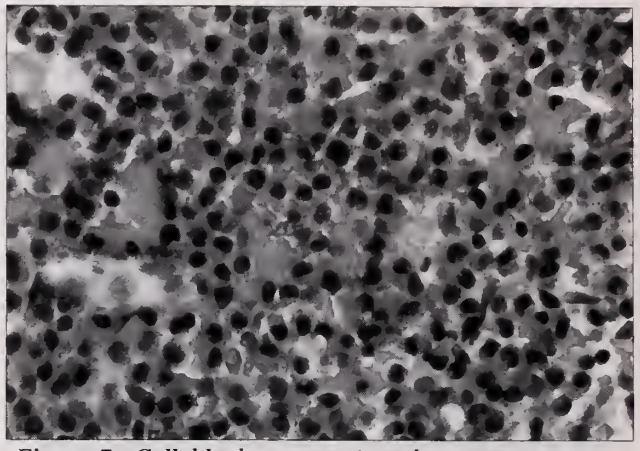


Figure 7: *Cell block preparation showing monotonous population of plasma cells.*

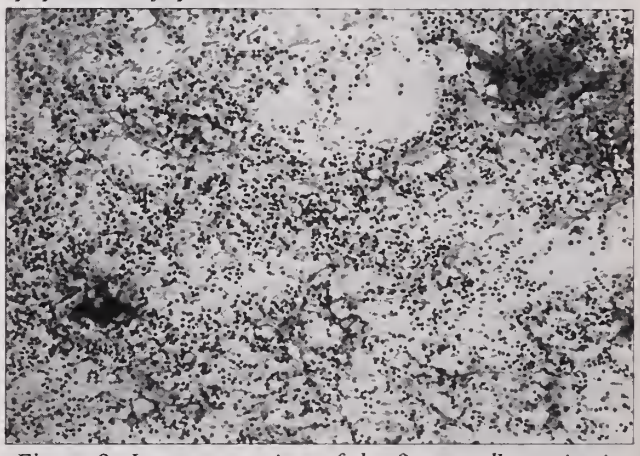
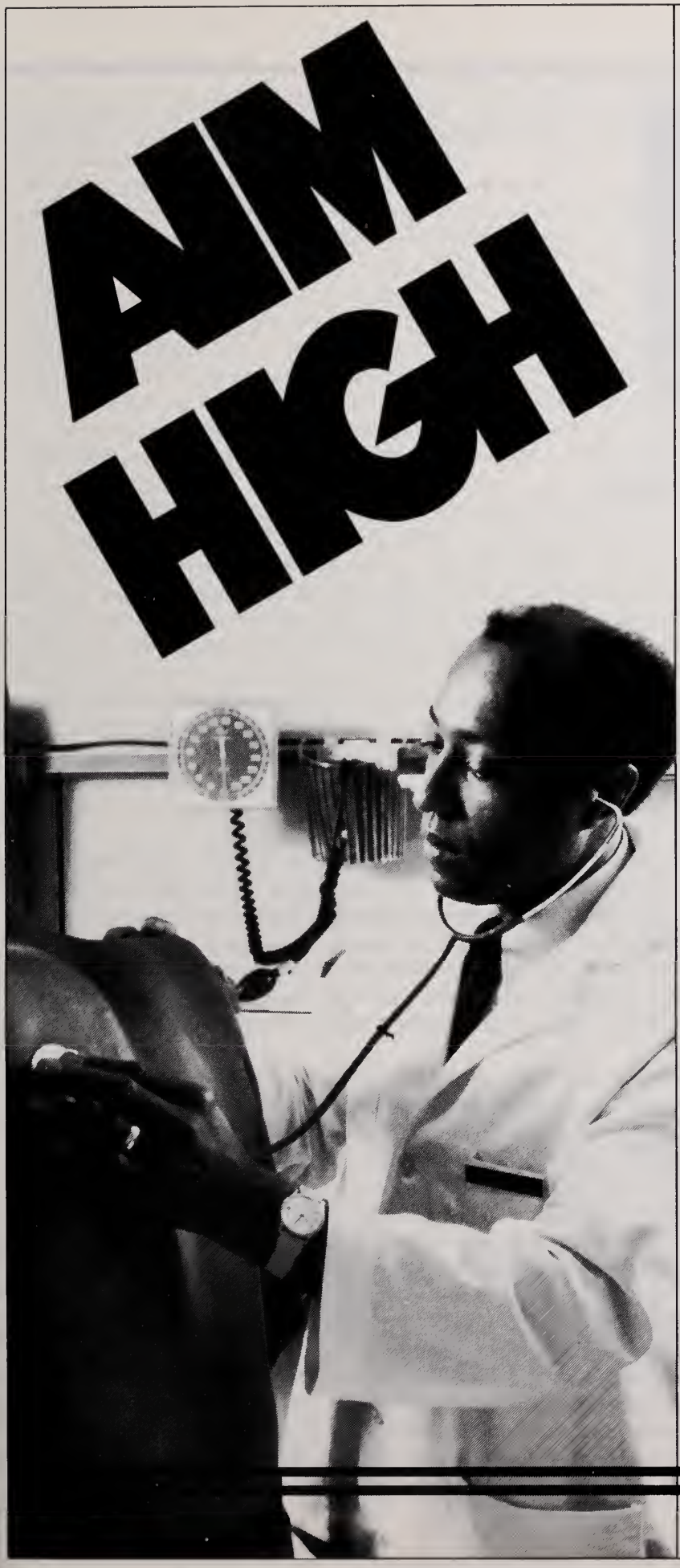


Figure 8: *Low power view of the fine needle aspiration smear. Note single cell distribution.*

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AIR FORCE



Fred L. McMillan, M.D.

The President's Page

What's Happening at the Med School

Ever wonder what is happening over at the Med School? What changes have come about in the medical students curriculum? I talked to Dean Wally Conerly, M.D., Associate Dean Dr. Helen Turner, along with Barbara Austin, head of Public Relations. Mississippi's medical school is doing great. First, we are fortunate that we have only one medical school in the state. Most other areas where there are numerous medical schools have a surplus of physicians, too many hospitals, too many faculty, and too many conflicting objectives. Here we can have a single purpose through one institution and they are doing a great job.

The application rate is 6.3/1 overall applicants per first year position with a 3.8/1 ratio for Mississippi applicants. The national average overall is 2.87/1. The Admissions Committee gives strong preference to Mississippi applicants. Women represent approximately 30% of the students and minorities about 9%. There are 100 students in each beginning freshman class with about 95 of these graduating. UMC students continue to do well on the standardized national board examinations. Recent results from the United States Medical Licensure Exam Step III revealed that 97% of the UMC students passed the first time and 100% passed on repeat. This is compared to 95% and 85% respectively nationally.

The medical students who go elsewhere for their residencies consistently say that they were better prepared clinically than their counterparts, and department heads elsewhere frequently send back letters saying the same thing.

Probably one of the main reasons for this is that UMC and the Liaison Committee on Medical Education (the medical school accreditation body composed of Representatives from the AMA and the Association of American Medical Colleges) stress primary care instruction. There are 40 weeks of primary care training at UMC compared to 31 weeks nationally. There

are 18 weeks of ambulatory care training (clinics) compared to 4.8 weeks nationally. At present 43% of all physicians in the state are graduates of UMC and 63% of the graduates are practicing in Mississippi with approximately 63% of the graduates going into primary care specialities.

Third year medical students take a six week preceptorship outside the medical school with one of about 100 volunteer physicians in family practice. The students take a lap top computer with them for these six weeks. With this they modem back their histories and physicals for critique and grading by the faculty. They also E-mail questions and discussions about particular patient problems. They are able to access the Rowland Medical Library as a reference resource. I understand that almost all students at the University have their own E-mail address. Along this same line, the medical school has a top notch computer lab that is highly utilized where they can work through simulated clinical scenarios. As these students move out into practices computers and telemedicine will be an integral part of their diagnostic and treatment armamentarium.

A relative new course addition to the curriculum is senior seminars. This is a two hour per week course given in three sections a year so that the class size is limited to about thirty students. The multiple topics covered include managed care, healthcare economics, women's health issues and ethics. The latter is also taught during the second year through several different courses.

UMC students have significant input into the medical school curriculum through two areas. One is their voting representation on the Curriculum Committee which is composed of sixteen faculty and four medical students - one from each class. The other input is through a newly formed Carl Gustav Evers Society. Dr. Conerly made a site visit to LSU and came back impressed with their Aesculapian Society and felt that something similar would fit well into his plans for more student involvement in their education at the Medical Center here. After his meeting with the students, a group assembled in the summer of 1995 and spearheaded by Dr. Donna Cassel, a student at the time, they wrote their bylaws. It was their decision to name their society for an individual having significant meaning to their lives and medical careers and thus the Evers Society was named after Dr. Carl Evers. This is a student led group with representation from each class. The members are elected by their peers with the only stipulation being that none can be class officers. Its mission is to improve the medical school and to serve the students. Funding for the Evers Society began from the Dean's office and subsequently received a significant gift from the Evers' family. The society members evaluate the courses and meet directly with the Dean thus giving the students direct input into how their courses are structured and taught. They also recognize excellence in teaching with recognition being given to multiple faculty members each year. I find it extremely fitting that the medical students have been given the opportunity for this type of input into their education in Carl Evers name. He always placed the students first.

So each new class of physicians continues to be extremely well prepared for taking care of their patients and we physicians and patients alike- are all better because of it.

Fred

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 1
JANUARY 1997

Ecological Disasters

The recent incidents of gross misuse of pesticides occurring in Mississippi once again calls our attention to the dangerous, disastrous, and very long lasting results which can occur, producing immense medical and environmental problems. These reports stimulated a recall of an editorial written in the early 1970's and I think it appropriate to repeat that message at this time. Hopefully the message expressed in the following will serve as a reminder of the importance of understanding and controlling all such activities.

In an address before the Economic and Social Council of the United Nations in 1965 Adlai E. Stevens said, "We travel together, passengers on a little space ship, dependent on its vulnerable supplies of air and soil, all committed for our safety to its security and peace, preserved from annihilation only by the care, the work, and I will say the love we give our fragile spacecraft." This address is only one of many signaling the dangerous imbalance developing between man and his earthly environment.

We would all like to believe that these problems are limited to other regions, however, this is not the case. Environmental problems are present in our state and those of us who have been fortunate enough to live in Mississippi for many years and have enjoyed its streams, clean air, pleasant climate, and other natural blessings should be more concerned than we are at the development of these imbalances. As physicians and leading members of our respective communities, we should all become active in preserving these things by acting and speaking out against special interest groups with limited and self-serving goals. Over recent months there have been many news releases regarding further industrialization of our state. While realizing and acknowledging that growth is necessary, we should all do our part to see that it comes about in an orderly and concerned manner with firm assurances that our natural gifts and resources will not be used in such a way as to produce irreversible imbalances; thus preserving for future generations all of our earthly gifts and treasures.

In a letter to the editor of *THE JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION* regarding environmental problems, Dr. C. Warren Irvin Jr., made the following statement: "The constantly growing population which seems to be a main concern of the Chamber of Commerce is evident to us all. Certainly the financial status of even the poorest of our citizens is better than it was for many years, but I am concerned that his way of life is better, and I am certain that his children's way of life will never approach that of previous generations unless some radical changes are made."

Even if we choose not to become involved politically and actively on a local or statewide basis in regard to these matters, as physicians we should still be concerned with the physical and mental illnesses produced by such changes. The physical problems created by air and water pollution, widespread usage of pesticides, herbicides, or other organic chemicals, industrial waste, heavy metal poisoning, exposure to radioactive material, and the more recently acknowledged effects of electromagnetic radiation demand development of medical awareness of these problems, a clinical alertness to their effects on humans, and proper medical management of the resulting illnesses. Preventive medicine has long been one of the major objectives of the medical profession. It, therefore, seems only natural that as physicians we should become involved, if for no other reason that to attempt to prevent such illnesses in our population.

Dr. Rene Dubois in a speech before the American Association for the Advancement of Science made the following statement: "Humanizing the earth thus implies much more than transforming the wilderness into agriculture lands, pleasure grounds, and healthy areas suitable for the growth of civilization. It also means preserving the kind of wilderness where man can experience mysteries transcending his daily life, and also recapture direct awareness of the cosmic forces from which he emerged." Let's all become active in preserving what we have and assuring ourselves, our children, and future generations not only a clean environment, but an environment with all of the pleasures we have previously enjoyed, and an environment with some wilderness where all of us can experience the mysteries pervading our daily lives.

-Myron W. Lockey, M.D., Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.
- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.
- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.
- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.
- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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Foundation Project Promotes Stroke Prevention

The Foundation for Medical Care (FMC) has recently been involved in two health care quality improvement projects directed at stroke prevention. The objective of both projects is to inform physicians in the state of the effectiveness of the use of warfarin to prevent stroke in patients with atrial fibrillation.

Atrial fibrillation is a disorder affecting increasing numbers of Americans. Estimates of its prevalence based on the Framingham study suggest that 4% of the adult population may have this condition. The incidence of atrial fibrillation rises with age, from 2 to 4% at age 60 to 16.1% of men and 12.2% of women over age 75. Patients with atrial fibrillation are nearly six times more likely to develop stroke than similar patients in sinus rhythm.

Five randomized multi-center trials have investigated the safety and efficacy of oral anticoagulation therapy for stroke prevention in patients with atrial fibrillation. These trials all reached remarkably consistent conclusions documenting approximately 70% reduction in stroke and very low rates of hemorrhagic complications with low intensity warfarin (INR Range 2-3).

According to the Agency for Health Care Policy and Research (AHCPR), Americans 65 years of age and over are the most likely candidates for atrial fibrillation. The risk of stroke in patients with atrial fibrillation is high and is increased with any of the following risk factors: advancing age, female gender, prior stroke or TIA, hypertension, diabetes, or heart disease. A total of 15,573 Medicare patients were discharged from Mississippi hospitals in 1995 with a primary or secondary diagnosis of atrial fibrillation.

To measure the utilization of warfarin in Mississippi Medicare patients with atrial fibrillation, the Foundation selected a sample of 355 charts for abstraction. Patients with a primary or secondary diagnosis of atrial fibrillation were selected from charts originally selected for a random 5% Medicare beneficiary sample and from statewide quality improvement projects. Forty patients who expired or transferred to other acute care hospitals during the stay were excluded from the study. The charts were then abstracted for the following information: discharge on an antithrombotic (warfarin, aspirin or ticlopidine), one or more stroke risk factors and rationale when the patient was not discharged on an antithrombotic.

Analysis of the 315 charts remaining in the study revealed 182 or 57.8% of the patients were discharged on some form of antithrombotic (warfarin, aspirin or ticlopidine). Warfarin, the drug of choice, was utilized in 113 patients, 35.9%, aspirin, 22.9%, and ticlopidine, 0.6%.

A total of 315 patients or 100% had at least one increased risk factor for stroke. Documentation of a rationale for not discharging the patient on an anticoagulant was rare. Only 17 cases, 5.4%, contained explicit reasoning for not discharging the patient on warfarin.

As part of this initial educational effort, a statewide letter, sent to over 1,200 physicians, contained the information concerning the atrial fibrillation project. The educational letter was signed by 11 physicians and one pharmacist representing prominent organizations in the state.

To promote additional education of providers, physicians and beneficiaries, nine hospitals agreed to collaborate in the Atrial Fibrillation/ Stroke Prevention Educational Project. All collaborators were invited to FMC offices for an introductory session. This session included all information and materials needed to educate physicians, staff and beneficiaries at their individual facilities. The Atrial Fibrillation "tool box" was given to each facility and included pretests, registration forms, evaluation sheets, videos, overheads, clinician handbooks, patient educational materials, and several reference materials.

At this time the educational

project is complete. The final evaluation results were positive. The majority of collaborators gave the project and the "tool box" materials excellent ratings.

The second and current Atrial Fibrillation Stroke Prevention Health Care Quality Improvement Project (HCQIP) involves eight collaborators across the state. These collaborators were also invited to FMC for an introductory session and given the materials for educational efforts. These facilities will submit improvement plans and monitor the effectiveness of all interventions.

To evaluate the utilization of warfarin for baseline measurement in the eight Mississippi hospitals participating in this study, FMC selected Medicare patients with atrial fibrillation as a primary or secondary diagnosis. Record review included 100% of the discharges from each facility between March 1, 1996, and May 31, 1996. The study included 843 records. A total of 101 patients in the study were excluded because they expired, transferred to another acute care hospital or left AMA. Also excluded were 14 patients with no documentation by history or current finding of atrial fibrillation in the chart. This left 728 patients in the study group.

•Of the 728 patients in the study, 263 (36%) were discharged on warfarin. Almost one-third of the patients discharged on warfarin were not on warfarin prior to admission.

•All patients had at least one additional risk factor for stroke.

•More than half of the patients in the study had a PT performed during the hospital stay, 431 (59%). Of these patients, 322 (75%) had the results converted to an INR.

•Aspirin was prescribed for 180 (25%) of the patients. Most of the 103 patients (57%) discharged on aspirin were over 75 years old.

•The majority of the patients in the study were over 75 years old, 415 (57%). There were more women, 414 (57%), than men, 314 (43%).

The above information and the hospital specific data were presented to the medical staff and the project team at the individual hospitals.

This second project is an ongoing monitoring process for the continuation of stroke prevention in patients with atrial fibrillation.

While the outcome of the efforts of these projects is not known at present, the presentation of the statewide letter and the "tool box" at the recent Stroke Belt Consortium received recognition and praise for the methods used in the state to reduce strokes in atrial fibrillation patients.

For more information, contact Mary Helen Conner, RN, BSN, project manager, at 601-354-0304.

Physicians' Recognition Award



Six MSMA members were named recipients of the AMA Physicians Recognition Award in November 1996. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Mississippi Medical Society
Samuel Philip Hopper, MD

Coast Counties Medical Society
Sidney Albert Chevis, MD

North Mississippi Medical Society
Ramon Harvey Rosenkrans, MD

Northeast Mississippi Medical Society
Mary Ellis Pace, MD

South Central Mississippi Medical Society
Steven Barry Liverman, MD

Singing River Medical Society
Gary Henry Groff, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Richard Jennings Field, Jr., M.D. Day

Richard Jennings Field, Jr., M.D. was honored for his forty years of medical leadership with a golf tournament, dinner and proclamation in his name. Guided by the Mississippi Chapter of the American College of Surgeons (MCACS), the Mississippi State Medical Association and the Mississippi Economic Council, Governor Kirk Fordice declared November 13, Richard Jennings Field, Jr., M.D. Day. The State Chapter of the American College of Surgeons planned a golf tournament and dinner at the Country Club of Jackson.

Dr. Field has served an extremely outstanding rural community hospital assuring Amite and Wilkinson counties medical care equal to and better than most other rural communities in the nation. The Field Memorial Community Hospital was originated by his father, R. Jennings Field M.D., and his uncle, Sam Field M.D.

As a member of the American College of Surgeons Dr. Field has distinguished Mississippi by serving on the Board of Governors, the Board of Regents and as vice-president of this international organization. He is currently a clinical professor of surgery at the University of Mississippi, Tulane University and Louisiana State University. Dr. Field holds undergraduate and medical degrees from Tulane University.

Dr. LaSalle Leffall, president of the American College of Surgeons and chairman of the Department of Surgery of Howard University, Washington, D.C., spoke at the dinner. Also paying tribute to Dr. Field's accomplishments were: Dr. James D. Hardy, Emeritus Professor, Chairman Department of Surgery, University of Mississippi School of Medicine; Dr. William Whitehead, President of the MCACS; Dr. Ron Kennedy, Seceretary of the MCACS; Dr. Henry Tyler, MS Governor to the Board of Governors of the MCACS; Dr. Fred McMillan, President of the Mississippi State Medical Association; Bob Pittman, President of the MS Economic Council, and Dr. Wallace Conerly, Vice-Chancellor of the University of Mississippi School of Medicine. Presenting the proclamation for the Governor was Dr. Briggs Hopson.



Dr. Robert Davis Field of Tupelo; his son Robert Davis Field, Jr. of St. Francisville, Louisiana; Dr. Ed Field of Oxford, son of Dr. Richard J. Field, Jr., far right



Dr. Richard J. Field, Jr. and his son, Dr. Ed Field



Dr. LaSalle Leffall, president of the American College of Surgeons and chairman of the Department of Surgery of Howard University, Washington, D.C., Dr. Richard J. Field, Jr. and Dr. Raymond Martin of Jackson.



Dr. LaSalle Leffall and Dr. Richard J. Field, Jr.



MSMA President Dr. Fred L. McMillan and his wife Loni Eustace-McMillan.



Dr. Richard J. Field, Jr. and MSMA President-Elect Dr. Vann Craig of Natchez.



Dr. Dewey H. Lane of Pascagoula and Dr. George V. Smith of Jackson.



Dr. Pete Hollis of Amory and Dr. Richard H. Clark, Jr. of Hattiesburg.



Dr. LaSalle Leffall, Dr. Carl M. Reddix and Dr. Helen Barnes.



Dr. LaSalle Leffall, Dr. Helen Barnes, Dr. Raymond Martin and his wife, Margery

UMC School of Health Related Professions Expansion



The Future School of Health Related Professions

The School of Health Related Professions (SHRP) at the University of Mississippi Medical Center has become the largest school on the Medical Center's campus—25 years after its authorization.

"Enrollment has continually increased in SHRP over the past several years," said Dr. J. Maurice Mahan, SHRP dean. "Our current enrollment is 382. This constitutes an almost 67 percent increase just since the past five years."

Initially, according to Jack Gordy, SHRP assistant dean, very little serious consideration was given to the allied health professions in state higher education. But in his 20 plus years of working at the Medical Center, he has witnessed SHRP's birth and its rapid expansion. The Board of Trustees of State Institutions of Higher Learning authorized the school in October 1971.

Another turning point in the increased awareness of the importance of allied health was SNAP, Statewide Network of Allied Programs, funded by a Veteran's Administration grant. Funding allowed for five additional staff for SHRP, then called the School of Allied Health Professions. These employees traveled the state providing preprofessional consultation and information at career fairs, in-service educational programs, medical terminology seminars, seminars on supervisory management, and introduction to the metric system seminars.

"We had a very fuzzy idea of what allied health was. There were few role models—none within the state," Gordy recalls. "When people thought of health care careers they focused on becoming a doctor or a nurse."

Typically, the five made contact with 4,000-6,000 students each year at an estimated 200-400 sites within the state. Every junior, senior, and community college and major high schools were visited at least once per year. Also,

Gordy says, close contact with minority institutions was established and has been maintained.

SNAP's objectives were to encourage students to pursue careers as allied health professionals, increase the level of awareness and the applicant pool in all programs in the School of Allied Health (SHRP) and to access the state's need for these health team members.

Funding for SNAP lasted from 1974-1981. Even after the funding stopped, SNAP continued, Gordy said.

"Actually SNAP never stopped. The funding ended, but SHRP continues to engage in these same activities, simply because SNAP was so significant in the development and progress of the school," he said. "Only now, the burden is transferred to the dean's office and the faculty in SHRP."

The school currently offers baccalaureate degree curricula in clinical laboratory sciences, cytotechnology, dental hygiene, health information management, occupational therapy and physical therapy and a certificate program in emergency medical technology.

Since 1957, 1,434 degrees and 449 certificates have been awarded in allied health programs.

"What I've seen is a school that has grown to meet the needs of Mississippi in terms of service and education," Gordy says. "I am most impressed by the leadership role the school has taken in allied health in this state."

SHRP was first to develop an occupational therapy program in Mississippi. It took hospital-based certificate programs and strengthened and upgraded them to baccalaureate status and added new programs that were needed in the state. SHRP also has assisted other state schools in similar allied health program development.

"What makes my job fun is we're never sitting still," he said. "We're always looking at new programs, new ways of doing things and new activities."

Growth has been so constant that $12 million in funding has been approved by the state for an academic building. The school now occupies what was once a men's dorm on Lakeland Drive and leases space in buildings across the street.

Dr. Mahan says that even more growth is anticipated. "We're pretty much at the projected number we thought we'd have for the new building."

"I'm not sure how much bigger we'll really get. We can't tell what's going to happen with Medicaid and Medicare, but we are market driven and flexible and, able to meet the needs of a changing population. Programs, for instance," Dr. Mahan says, "have opened and closed over the years depending on demand. As long as the population needs to be served, we're going to be here to do that."

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Brain Injury Association Honors Stuart Yablon, M.D.



Stuart Aaron Yablon, M.D.
Brain Injury Program Director
Mississippi Methodist Rehabilitation Center

The Brain Injury Association, formerly the National Head Injury Foundation, recently named Stuart Aaron Yablon, M.D., as its "1996 Young Investigator."

This prestigious award is presented to an individual who has made significant contributions to improve the care and rehabilitation of persons with brain injuries.

In just a few short years, Dr. Yablon has established himself as an accomplished researcher and respected teacher. We are proud to have him as Director of the Brain Injury Program at Mississippi Methodist Rehabilitation Center.

It is because of people like Dr. Yablon that we have earned our reputation as an industry leader and have made a difference in the lives of so many patients.

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Dr. Ben M. Carmichael *of Hattiesburg entertained guests with Christmas tunes on the piano at the MSMA Board Dinner held Friday, December 13, 1996 at the Mississippi Museum of Art in downtown Jackson.*



MSMA President Dr. Fred L. McMillan *and his wife,* ***Loni Eustace-McMillan.***



MSMA Board members led guests in singing Christmas carols. Shown left to right, ***Dr. Sidney O. Graves, Jr.*** *of Natchez,* ***Dr. Dewitt G. Crawford*** *of Louisville,* ***Dr. Ben M. Carmichael*** *of Hattiesburg, MSMA Executive Director* ***Charles L. Mathews, Dr. Leonard Brandon*** *of Starkville,* ***Nickie Wiebelt,*** ***Dr. Don Q. Mitchell*** *of Jackson, MSMA Past-President* ***Dr. D. Stanley Hartness*** *of Kosciusko.*



Dr. Sidney O. Graves, Jr. *of Natchez,* ***Dr. Dewitt G. Crawford*** *of Louisville,* ***Dr. Ben M. Carmichael*** *of Hattiesburg (seated),* ***Charles L. Mathews of Jackson, Dr. Leonard Brandon*** *of Starkville.*



Beth Hartness** and **Dr. Stanley Hartness



Dr. Sidney O. Graves, Jr.** and **Ester



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New Members

CALHOUN, WILLIAM B., Tupelo. Born Natchez, MS, February 4, 1963; MD Louisiana State University School of Medicine, Shreveport, LA, 1991; internal medicine residency, University of Florida Medical Center, Gainesville 1989-92 and cardiology fellowship 1993-96; elected by Northeast MS Medical Society.

DERBES, LAWRENCE JOSEPH, Biloxi, Born Baton Rouge, LA, July 30, 1959; MD Louisiana State University School of Medicine, New Orleans, LA, 1985; internal medicine residency, University of South Florida Medical Center, Tampa, FL, 1985-88; cardiology fellowship, University of California Medical Center, Davis, CA, 1988-90; one year fellowship, electrophysiology, Ochsner Foundation Medical Center, New Orleans, LA, 1994-95; elected by Coast Counties Medical Society.

DALY, EDWARD F., III, Natchez. Born January 3, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1992; internal medicine residency, University Medical Center, Jackson, MS, 1992-96; elected by Homochitto Valley Medical Society.

FOWLKES, LAURA P., Oxford. Born Champaign, IL, November 22, 1957; MD University of Tennessee College of Medicine, Memphis, TN, 1989; interned and internal medicine residency, University of Pittsburgh Medical Center, Pittsburgh, PA, 1989-92; cardiology fellowship, University of Tennessee Medical Center, Memphis, TN, 1992-95; elected by North MS Medical Society.

GRANT, WALTER K., Pascagoula. Born New Orleans, LA, July 13, 1961; MD University of South Alabama School of Medicine, Mobile, AL, 1989; pediatric residency, Brooke Army Medical Center, San Antonio, TX, 1989-93; elected by Singing River Medical Society.

HEITZMAN, HARRY BRADLEY, Ocean Springs. Born Biloxi, MS, October 26, 1943; MD University of Mississippi School of Medicine, Jackson, MS, 1969; internal medicine residency, University Medical Center, Jackson, MS, 1970-73; elected by Singing River Medical Society.

HINES, SARAH H., Jackson. Born Gadsden AL, November 20, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1987; anesthesiology residency, University of Kentucky Medical Center, Lexington, KY. 1988-91; elected by Central Medical Society.

KELLY, CHARLES S., Ackerman. Born Hammond, IN, June 27, 1965; DO West Virginia School of Osteopathic Medicine, Lewisburg, WV 1993; family medicine residency, Ochsner Medical Foundation, New Orleans, LA, 1993-96; elected by North Central Medical Society.

KHAN, SAAB M., Sumrall. Born Pakistan, September 14, 1967; MD Dow Medical College, Pakistan 1992; internal medicine residency, St. Lukes Hospital, Case Western Reserve University Medical Center, Cleveland, OH, 1992-95; elected by South MS Medical Society.

LIBYS, JAY J., Gulfport. Born Washington, DC, September 24, 1958; MD West Virginia School of Medicine, Morgantown, WV, 1987; internal medicine residency, University of South Carolina Medical Center, Charlestown, SC, 1987-90; cardiology fellowship, Mt. Sinai Medical Center, New York, NY, 1992-95; elected by Coast Counties Medical Society.

SARIEGO, JOAQUIN, Newton. Born Philadelphia, PA, May 27, 1957; MD Jefferson Medical College , Philadelphia, PA, 1983; interned one year, same; general surgery residency, Medical College of Pennsylvania Medical Center, Philadelphia, PA, 1984-88; elected by East MS Medical Society.

SEQUEIRA, LYNETTE A., Columbia. Born Pakistan, May 12, 1960; MD Dow Medical College, Pakistan, 1985; pediatric residency, University of Texas Medical Center, Galveston, TX, 1992-93; pediatric residency, Childrens Hospital of Orange County, Orange, CA 1993-95; elected by South MS Medical Society.

THOMAS, CASSANDRA F., Jackson. Born Mount Bayou, MS, March 9, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1991; family medicine residency, University of Mississippi Medical Center, Jackson, MS, 1/93 - 9/95; elected by Central Medical Society.

WATERER, HENRY C., III, Jackson Born Greenwood, MS, March 9, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1985; internal medi-

cine residency, University of Mississippi Medical Center, Jackson, MS, 1985-88; cardiology fellowship, same, 1989-92; elected by Central Medical Society.

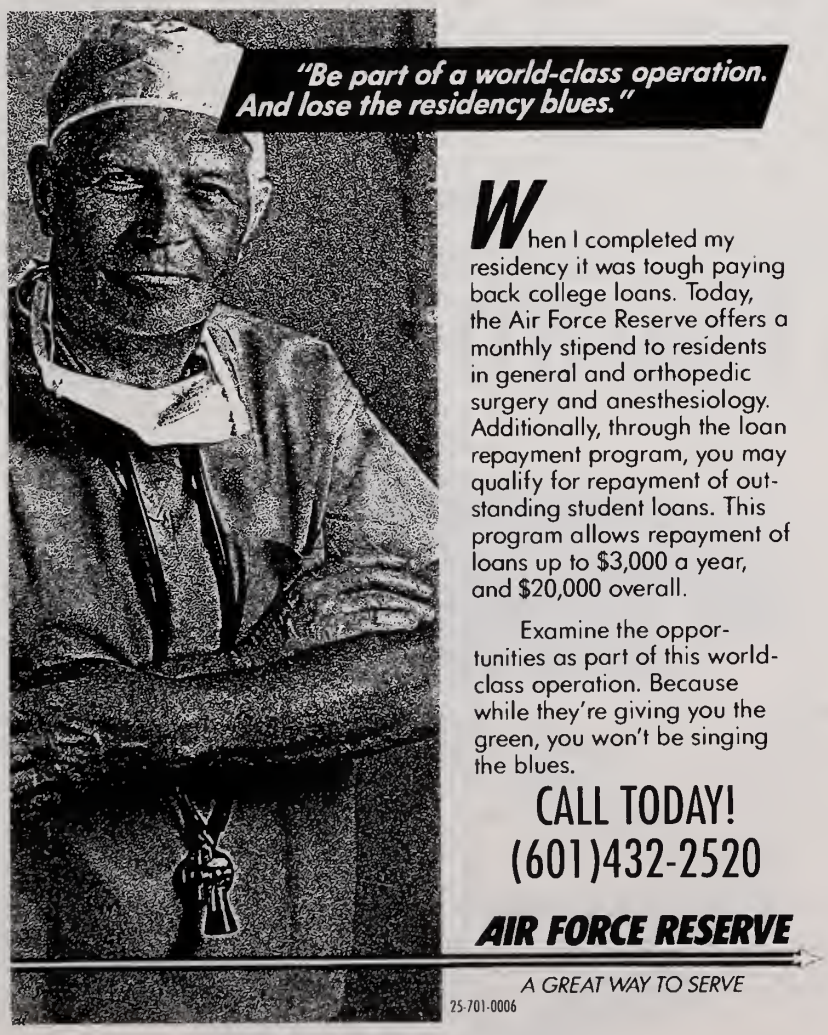
WESTBROOK, HOWARD G., Pascagoula. Born Jackson, MS, April 12, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; family medicine residency, University of Mississippi Medical Center, Jackson, MS, 1993-96; elected by Singing River Medical Society.

WESTON, LUCY A., Jackson. Born, Charlottesville, VA, December 14, 1961; MD Medical College of Virginia, Richmond, VA, 1991; anesthesiology residency, University of Virginia Medical Center, Charlottesville, VA, 1991-95; critical care medicine fellowship, same, 1995-96; elected by Central Medical Society.

ZAYED, MAHMOUD H., Ocean Springs. Born Cairo, Egypt, November 21, 1957; MD Kasrel Eini Faculty of Medicine, Cairo, Egypt, 1981; internal medicine residency, Muhlenberg Regional Medical Center, Plainfield, NJ, 1987-90; cardiovascular disease fellowship, Norwalk Hospital/Yale Univ. Program, Norwalk, CT 1990-93 and Baystate Medical Center, Tufts University Western Campus, Springfield, MA, 1993-94; elected by Singing River Medical Society.

DEATHS:

MCCOLLUM, CHARLES R., JR., Jackson. Born Marks, MS, February 24, 1937; MD University of Mississippi School of Medicine, Jackson, MS, 1966; interned & internal medicine residency, University of Mississippi Medical Center, Jackson, MS, 1966-69; gastroenterology fellowship, same, 1969-70; died December 11, 1996, age 59.



Don Q. Mitchell, MD, of Jackson, Miss., was recently presented the Distinguished Fellow award and elected treasurer for the fourth term by the American College of Allergy, Asthma & Irnmunology (ACAAI). Dr. Mitchell and five of his colleagues were recognized for their distinguished contributions to the specialty of allergy, asthma and immunology. The awards were presented in a special ceremony during the ACAAI annual meeting in Boston. Dr. Mitchell is clinical associate professor of medicine at the University of Mississippi School of Medicine and a private practitioner at the Mississippi Asthma & Allergy Clinic. He is a Fellow of the American College of Physicians. Dr. Mitchell has served aş ACAAI treasurer since 1993, and on the Board of Regents. He presently serves on the Executive Committee, chairs the Finance Committee, chairs the Publications Committee and co-chairs the Committee of 200. Dr. Mitchell is also active on the Executive Committee and Board of the Mississippi Physicians Care Network (Managed Care), vice president and member of the Board of the Mississippi Physicians Insurance Company (Workmen's Compensation) and serves on the Board of Governors of the American Association of Certified Allergists.

Larry D. Field, MD recently participated as instructor at the Annual Arthroscopy Association Meeting of North America in Palm Desert, California. He presented several talks on advanced arthroscopic techniques in shoulder and elbow surgery and also participated as a laboratory instructor.

Syed S. Rafique, MD recently lectured on "Diagnosis, Prevention, and Treatment of Breast Cancer" for Greenwood Leflore Hospital.

A. Dean Cromartie, MD, of Hattiesburg, has been appointed to the Infant Mortality Task Force. He will represent the State-at-large for the unexpired term ending June 30, 1998.

Steven E. Farrell, MD joined the Hattiesburg Clinic in the practice of internal medicine. His office will be located at Hattiesburg Clinic West.

Francis S. Morrison, MD, Professor Emeritus of Medicine, recently returned from Florence, Italy, where he presided as outgoing president, over the 6th International Congress of the World Apheresis Association. At the post-convention board meeting, he was elected president of the newly formed WAA Foundation. He will direct a Board of Trustees which will manage funds from the industry to make awards and travel grants to further the educational and recognition efforts of the Association.

John J. McGraw, MD of Ellisville, was honored by William Carey College (WCC) with the Distinguished Alumna Award at a Homecoming Awards Luncheon held recently on the Hattiesburg campus. An orthopaedic surgeon at the Laurel Bone and Joint Clinic, McGraw is a diplomat in the American Board of Orthopaedic Surgeons and a fellow in the American Academy of Orthopaedic Surgeons. McGraw, who served as president of the William Carey College Alumni Association from 1989 - 1991, donates much of his time to the medical mission field. He is a member of the Doctors Four, a singing quartet, and the Mississippi Singing Churchmen.

Alan E. Freeland, MD, Professor, Department of Orthopaedic Surgery, was a guest lecturer at a course on the Treatment of Hand Fractures at the Pulvertaft Hand Center in Derby, United Kingdom.

Aurelio Muyot, MD has joined **Dr. Troy Cappleman** in the office of Healthcare Associates for the practice of Internal Medicine and Geriatrics at Tippah County Hospital.

Stuart A. Yablon, MD was presented the Young Investigator Award by the Brain Injury Association at an awards luncheon during its recent 15th Annual National Symposium held in Dallas, Texas. This prestigious award recognizes individuals whose scholarly contributions and research have advanced the field of head injury rehabilitation. Recipients are also required to be within five years of

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

completing their professional training. Dr. Yablon serves as Director of the Brain Injury Program at the Mississippi Methodist Rehabilitation Center (MMRC) in Jackson.

James Rayner, MD has opened Rayner Eye Surgery Center in Oxford. Staffed by Drs. Joe Supple, Randy Richardson, and Phil Gannaway, it is the first ambulatory eye surgery center in northern Mississippi.

Ralph Vance, MD, professor of medicine at the University Medical Center, has been elected chairman of the board of directors of the Mid-South Division of the American Cancer Society. The boards of the Alabama, Arkansas, Louisiana and Mississippi divisions merged to create the new multi-state division this month.

John Morrison, MD, chairman of ob-gyn at the University Medical Center, received the National Perinatal Association's Individual Contribution to Maternal/Child Health award at the association's annual meeting.

James C. Waites, M.D., a Family Practice physician in Laurel, was elected Vice-Chairman of the Council of the Southern Medical Association (SMA) for 1996-1997 during the Association's 90th Annual Scientific Assembly held in Baltimore, Maryland in November. The Council, the policy-making body of the Association, consists of seventeen councilors representing the sixteen states and the District of Columbia which constitute the territory of the Association. Southern Medical Association fulfills its mission to develop and foster the art and science of medicine by planning and presenting approved continuing medical education (CME) programs for physicians, with the ultimate goal of enhancing patient care. SMA's Annual Assembly is the largest regional CME meeting held in the United States.

Michael E. Jabaley, MD, FACS was in Washington, D.C. in early December as the 1996 Visiting Professor for the Metropolitan Washington, D.C. Society for Surgery of the Hand. Dr. Jabaley lectured on "Nerve Repair-1990's and Beyond" at the Walter Reed Army Medical Center and spoke at Georgetown University Hospital on "Dupuytren's Contracture." Dr. Jabaley is Clinical Professor of Plastic and Orthopedic Surgery at the University of Mississippi School of Medicine and has been in private practice for plastic and reconstructive surgery for over twenty years. Jabaley currently serves as President of the American Association of Plastic Surgeons and the Sunderland Society.

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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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Early Otorrhea Following Ear Tube Insertion

C. Ron Cannon, MD, FACS

Otitis media with effusion (OME) is a very common complaint in infants and young children; in fact thirty million prescriptions are written yearly for this entity alone. Children that fail medical treatment for OME are candidates for ear tube insertion.

Myringotomy with insertion of ear tubes has become the most commonly performed otologic procedure. Otorrhea following ear tube insertion is variable both in its frequency and severity. It may not occur at all following ear tube insertion or it may be constant. It may resolve spontaneously or may be persistent requiring treatment with both topical and systemic antibiotics. To the concerned parents of children with otorrhea it is often a stressful experience.

Otorrhea can be divided into early and late types.[1,2] Early otorrhea is defined as occurring within the first fourteen post operative days. Early otorrhea may be due to a number of different factors including the status of the middle ear space at the time of vertilation, bacterial status of the ear canal at the time of ear tube insertion, and surgical preparation of the ear canal at surgery.

Parameters of interest in this study included the following: Do systemic antibiotics lessen the frequency of otorrhea? Does surgical antisepsis of the ear canal lessen the incidence of otorrhea? Does the use of topical ear drops decrease the incidence of otorrhea? Is there an optimal combination of ear canal antisepsis and topical drops which decreases otorrhea?

MATERIALS/METHODS

The patients enrolled in this study were all less than 12 years old and had ear tubes inserted by a single surgeon (CRC). The patients were all referred to the author by pediatricians and family physicians after failing a course of conservative medical therapy for OME.

None of the patients had a cleft palate, known neurosensory hearing loss, were immunocompromised, or were in an inpatient setting at the time of surgery. All of the patients underwent surgery on an outpatient basis. The tubes were inserted using an operating room microscope using sterile technique. Collar button tubes were used in each instance.

Ear canal preparation consisted of triple irrigation of the ear canal with a 50% solution of Betadine and saline for one minute prior to ear tube insertion. The topical drops used in each instance were Garamycin ophthalmic drops. The drops were instilled in the ear canal at the time of surgery and were used for several days

post operatively. The same instructions for ear drop usage were given to the parents of each child. The patients were randomly assigned in one of four groups. Group I - no ear canal preparation, no topical drops post operatively. Group II - ear canal preparation with Betadine, no ear drops post operatively. Group III - no ear canal preparation, use of ear drops after surgery. Group IV - ear canal-preparation with Betadine, use of topical ear drops post operatively. Patients were randomized into one of the four study groups in a prospective fashion until fifty patients were enrolled into each group (200 patients total). Cultures were obtained at the time of surgery and the results noted in those patients in whom otorrhea developed. All of the patients were seen at one week post operative and the ears examined for the presence of otorrhea. Otorrhea was defined as the presence of purulence in the ear canal or lumen of the ear tube.

RESULTS

A total of 50 patients were enrolled into each of the four study groups (200 patients total). The overall age of patients in the study was 25 months. The study group consisted of 59% males and 41% females. This male predominance is consistent with other studies of OME. Only 2% of those in the study were black. The demographics of the study group are depicted in Table I.

The use of antibiotics is a mainstay of treatment for OME. The chronicity of the OME is manifested in the finding that 97.5% of the patients were taking antibiotics at the time of surgery. The antibiotics used are listed in Table II. The most frequently used group of antibiotics were the Cephalosporins. These antibiotics were being administered to 57% of patients at the time of surgery. Of the Cephalosporin group cefoxime was the most frequently employed. Other antibiotic choices which were used commonly were Amoxil, Augmentin, Pediazole, Amoxicillin, Amoxicillin and potassium clavulanate, and Eryhromycin/Sulfisoxazole.

Effusions were not found universally at the time of ear tube insertion. In those cases where an effusion was found, note was made of whether the effusion was serous, mucoid, or purulent. Also noted was whether the effusion was thought to be copious or scant (See Table III). The middle ear effusion was classified as copious in 21% of the patients. Serous effusions was noted to be present in 25% of the patients and mucoid in 34% of the patients. The effusions were noted to be purulent in 27% of patients (Table III).

The children were seen at one week post operatively and the ears examined. The presence of purulence in the ear canal or in the lumen of the ear tube was considered to be indicative of post operative otorrhea (Table IV). Otorrhea was found in the following percentages for each group. Group I (no ear canal preparation, no topical ear drops used post operatively) - 8%, Group II (Betadine ear canal preparation, no ear drops used post operatively) - 10%, Group III (no ear canal preparation, topical ear drops used post operatively) - 14%, Group IV (Betadine ear canal preparation, ear drops used post operatively) - 10%. A one way chi-square test indicated that there was no difference in the proportion of patients in each group who had postoperative otorrhea ($X^2 = 1.01$, $p < .05$). Additionally, two patients in Group I were noted to have occlusion of one of their ear tubes by clotted blood. In those patients with otorrhea the effusions at surgery grew out Strept pneumoniae (5) most commonly followed by Pseudomonas (2), and Proteus (1). Of interest is the finding that many of the effusions were found to be sterile at the time of surgery.

COMMENT

Since the popularization of ear tube use by Dr. Beverly Armstrong in 1954 this procedure has become the most frequently performed otolaryngologic procedures It is generally agreed that otorrhea is the most common complication of ear tube insertion.

Otorrhea following ear tube insertion has been reported by other authors in the past. The rates of otorrhea vary widely. In a recent paper by Scott and Strunk the overall rate of otorrhea was 8.7%[4], low rates of early post operative otorrhea were found by Gates et al as well[5]. In a large study of over 2,000 patients Luxford and Sheely reported otorrhea in 19% of patients[6]. Similar rates of otorrhea have been reported by Birch and Mravee (15.1%)[7], as well as McLelland (19.9%)[8]. These reported rates of otorrhea are similar to the present study in which the overall rate of otorrhea was 10.5%. There was no observed clinical difference in the different groups in terms of the development of otorrhea. Thus it does not appear that sterilization of the ear canal with Betadine or the use of topical antibiotic drops decreased the incidence of post operative otorrhea. Scott and Strunk did note a decreased incidence of otorrhea using topical drops post operatively in patients with mucoid effusions[4]. This finding was not borne out in the present study.

Infection following ear tube insertion may be due to contamination from the ear canal, the middle ear space, or the ear tube itself. It is interesting that there has been a shift of antibiotic usage to the Cephalosporin class of drugs although the bacteriology of middle effusions has not changed significantly[8]. This also serves to indicate that antibiotic treatment of OME, unfortunately, remains

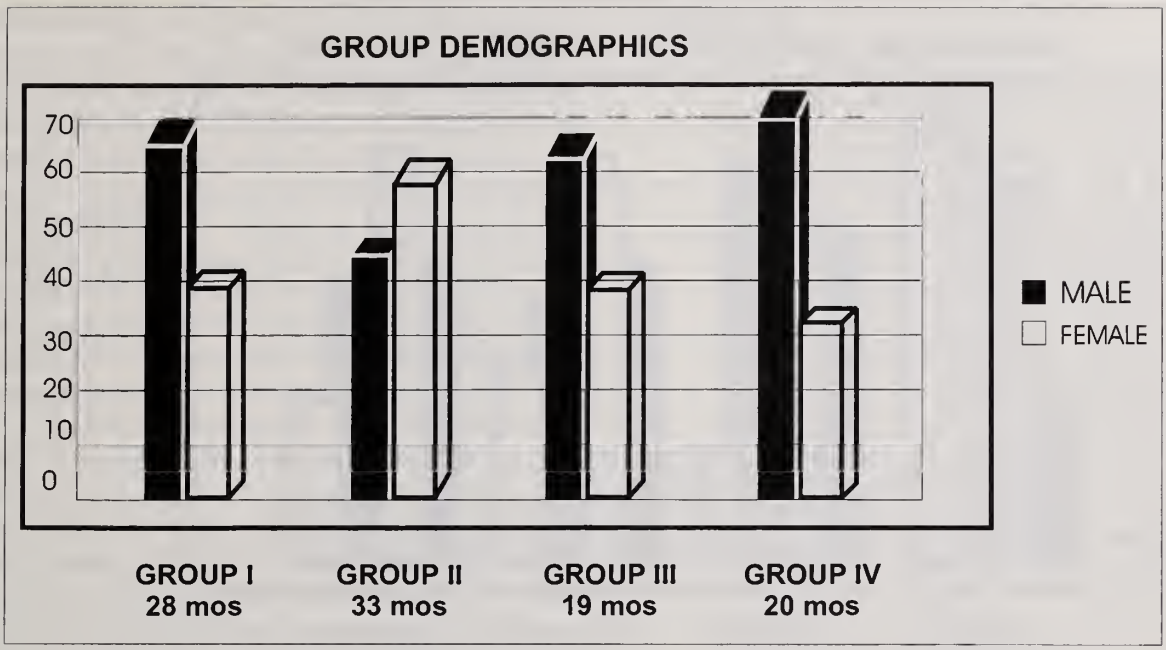


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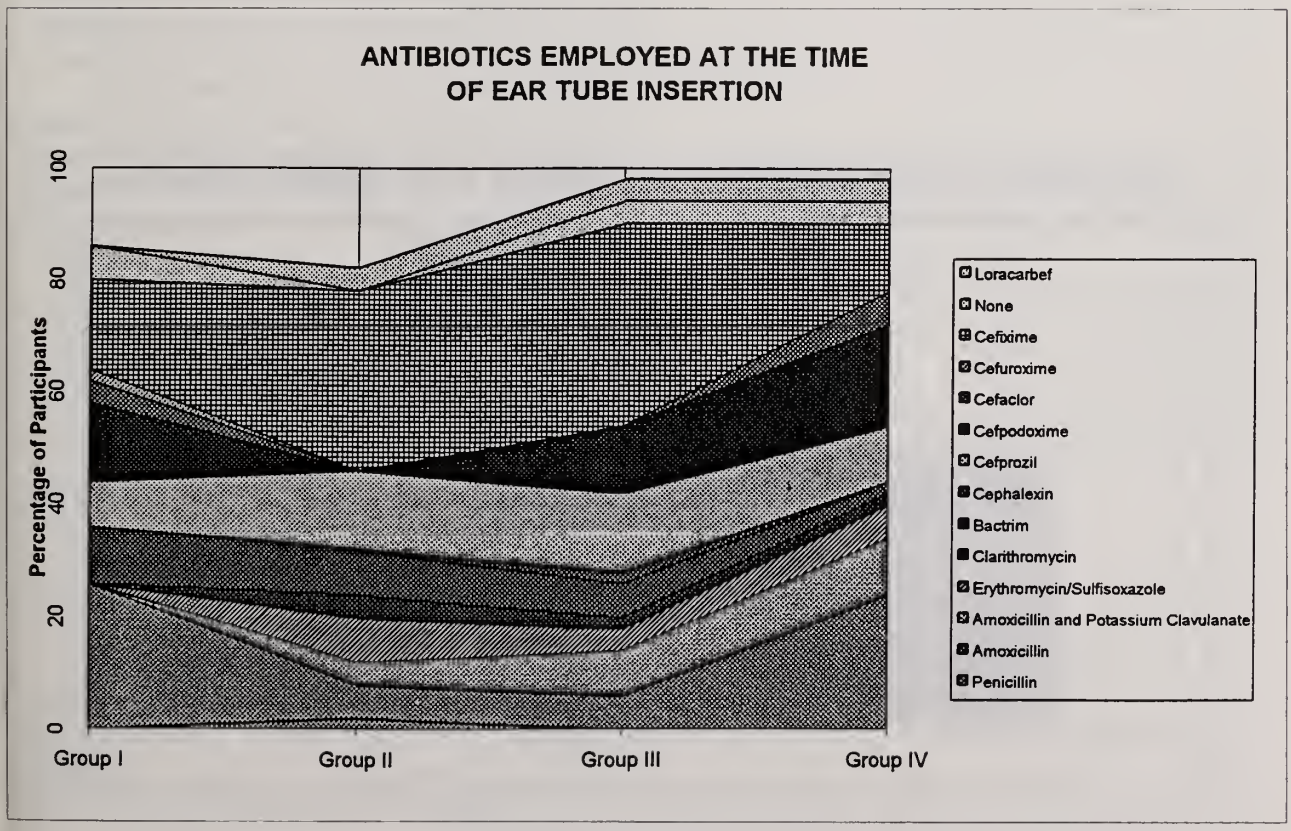


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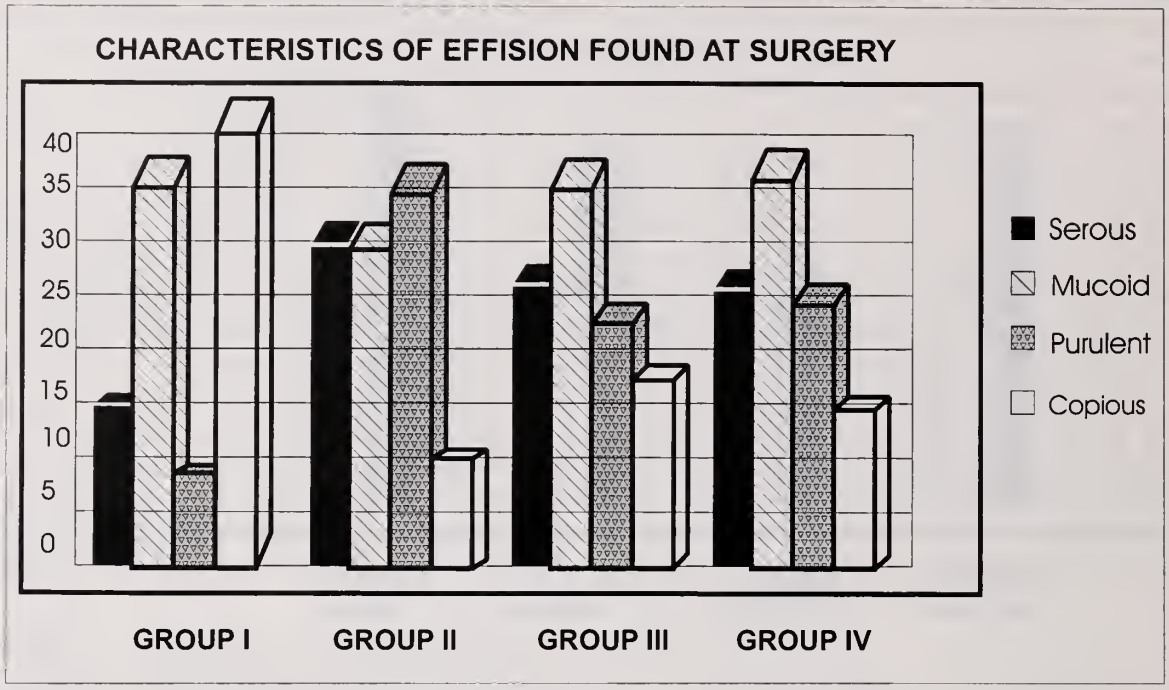


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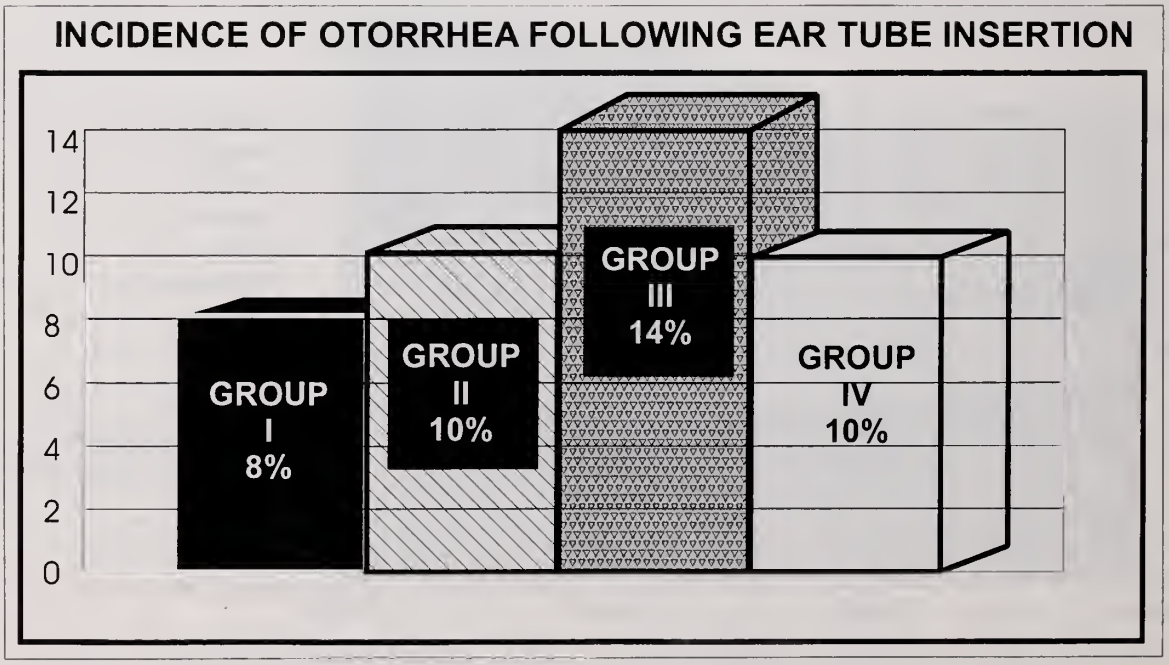


Table IV

unsuccessful in some patients. In this study Streptococcus pneumoniae was the most commonly found organism in the patients with otorrhea, indicating that the infection in the middle ear space is frequently the culprit in patients with early post operative otorrhea. Several patients with early otorrhea also cultured out Pseudomonas aeruginosa pointing out that the external ear canal must also be considered when treating otorrhea. A recent presentation by Duck et al has indicated that treatment with a topical drop in combination with a steroid increases the efficacy of treatment of otorrhea[9]. Should otorrhea develop, it has become the authors preference to treat children with a 10-14 day course of Erythromycin-Sulfa (Pediazole) and a topical Garamycin-Steroid drops (Tobra-dex) for 7-10 days. The combination of Erythromycin-Sulfa covers both Streptococcus pneumoniae and some strains of Pseudomonas aeruginosa. Clinically, this regimen usually results in prompt cessation of the otorrhea. A word of caution should be remembered when using topical ear drops. In an experimental study of chinchilla ears and topical drops, Meyerhoff et al, did note some ototoxicity[10]. The human round window, however, is significantly thicker than the animal model in this study. Meyerhoff et al also noted that in the presence of middle ear disease concerns about ear drops reaching the round window membrane are probably not justified and that ear drops are an acceptable form of therapy.

A new development in the treatment of post ear tube otorrhea is the use of ear tubes impregnated with silver oxide[11]. While this may have implications for long term or chronic otorrhea the results for early otorrhea were roughly the same for the test and control groups when using this new tube.

CONCLUSIONS

1. Despite the use of antibiotics, particularly those in the Cephalosporin class, middle ear effusions remain a persistent problem.

2. In the present study, sterilization of the ear canal and/or the use of topical drops did not result in lower rates of early otorrhea following ear tube insertion.

3. The immediate use of ear drops at surgery may help in decreasing clot formation within the lumen of the ear tubes. This has not previously been reported.

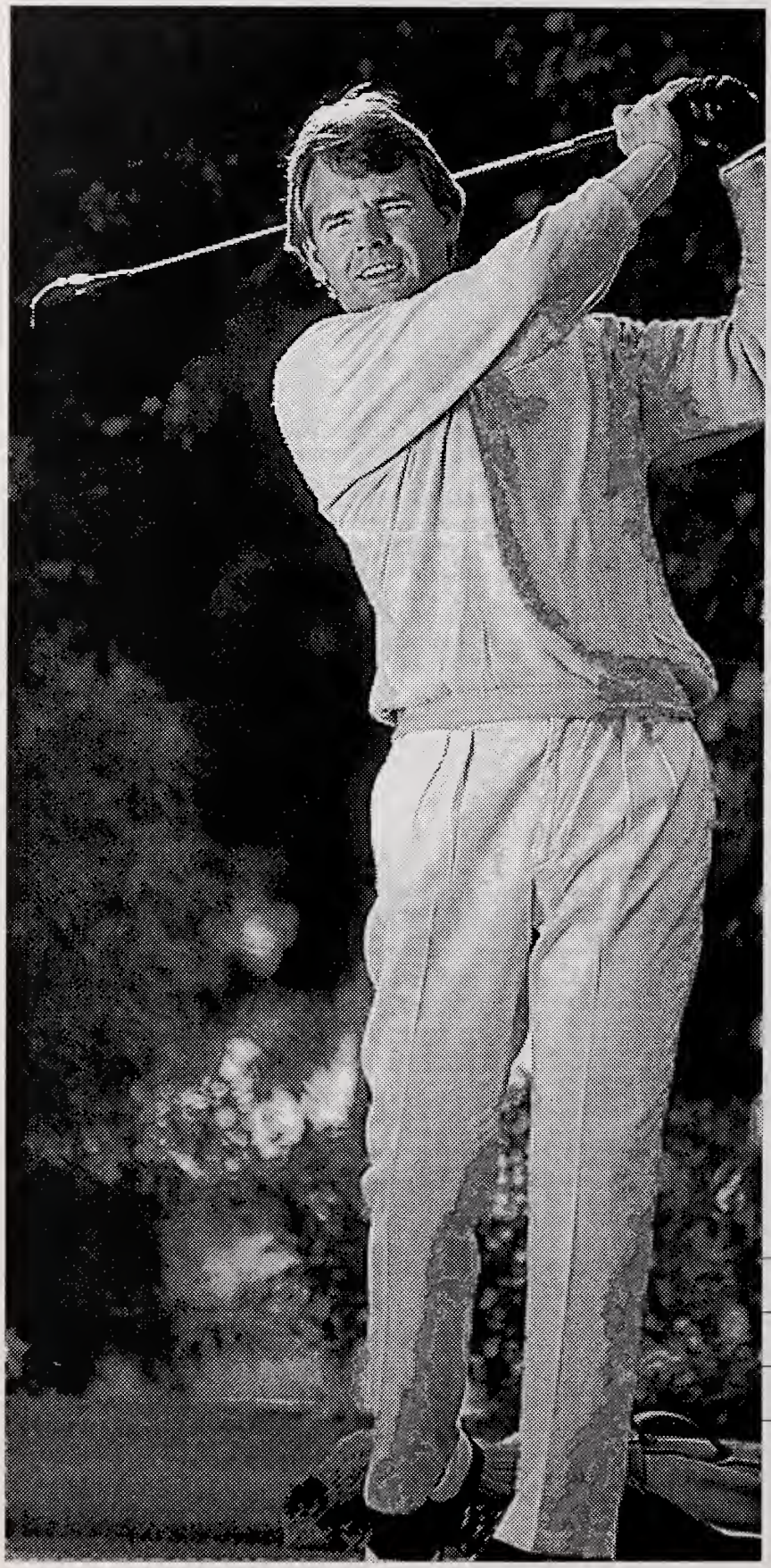
4. The author's present preference for treatment of early otorrhea following ear tube insertion is a combination systemic of Erythromycin-Sulfa and topical Gentamicin-Steroid drops. This treatment regimen usually results prompt cessation of the otorrhea.

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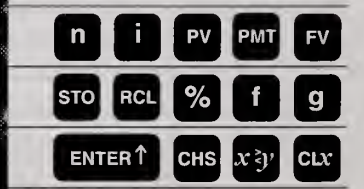
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Mississippi Selected Facts About Teenage Pregnancy

Mississippi State Department of Health
Division of Reproductive Health
Family Planning

F. E. Thompson, M.D., State Health Officer
Marilyn Johnson Luckett, MPPA, Health Program Specialist, Sr., Bureau of Women's Health

Introduction

Teenage pregnancy and childbearing have been a normal reproductive pattern in many cultures over many centuries. However, during the past several decades, that pattern has increasingly been presented as a major social problem, especially in the United States, which has the highest rates of adolescent pregnancy and childbirth among Western industrialized nations.[1] *Children having Children:* this powerful statement has been instrumental in making teenage pregnancy a major national concern. The issue of teenage pregnancy continues to greatly disturb our nation and our state, so much so that it demands immediate attention, although there exists no consensus as to what the problem really is.[2]

Research clearly suggests that much of the complexity and difficulty surrounding the issue of teenage pregnancy stems from inaccurate perceptions of what the problem is. Is it pregnancy in teen years? Is it morality - childbirth to teenagers outside of marriage? Is it sexual activity too soon? Is it failure to complete education or training? Is it the demands on the welfare system, or is it poverty?[3] These questions have a politically volatile nature. Although the issue has prompted much concern, it has not prompted coherent policies.

Teenage pregnancy has become the centerpiece for welfare reform. It has been identified as one of the major reasons for dropping out of school. Researchers contend that not only does teenage pregnancy cause poverty, but poverty is a cause of teenage pregnancy.[4]

What makes adolescent pregnancy problematic? Adolescence, as described by social scientists and the general American public, is a critical developmental stage where children undergo the physical, emotional, and social growths that prepare them for adulthood. Because of the perceived fragility of these young people, most parents, educators, politicians, social welfare agencies, health providers, and others view pregnancy during the early years as a disaster.[5]

Research indicates that the consequences of unintended pregnancies are serious, imposing burdens on children, their families, and society. Data reveal that 60 percent of all babies born in the US are unintended.[6] For the teen population that percentage increases to 95 percent.[7]

Studies further suggest that when pregnancies are unintended, especially when they are unwanted, the mother is less likely to seek prenatal care. If she does, usually it begins after the first trimester. In addition, the mother of

an unwanted pregnancy is more likely to expose the fetus to harmful substances such as tobacco and alcohol. Also, the child is at greater risk of being a low birthweight baby (less than 2,500 grams).[8]

The child of an unwanted conception is at greater risk of dying during the first year of life, of being abused, and of not receiving the necessary resources for healthy development. Studies show that the mother herself is at greater risk of being abused by her partner. Also, her relationship with her partner is at greater risk of dissolution.[9]

In Mississippi, over 22 percent of all babies born during 1994 were born to teenagers. More than 32 percent of those mothers were giving birth to their second, third, fourth, or fifth child. In addition, 80 percent of the teen mothers were unmarried. Approximately 44 percent of the teen mothers were 17-years-old or younger. About 85 percent of the reported pregnancies to adolescents resulted in births. The remainder resulted in abortions and fetal deaths.

In absolute numbers, these percentages mean that of the 41,938 babies born in Mississippi during 1994, teenagers gave birth to 9,265 of them. Within this pool, 2,118 girls gave birth to their second child, 566 gave birth to their third baby, and 159 gave birth for the fourth time or more. Data reveal that 7,383 of the 9,265 teen mothers were unmarried, and 4,114 girls were 17-years-old or younger. One mother had not reached her twelfth birthday. Sixteen 12-year-olds and 79 thirteen-year- old girls became mothers. Some 1,399 teenagers elected to terminate their pregnancy, while another 138 experienced a fetal death.[10]

Mississippi continues to lead the nation in the percentage of births to teens. Nevertheless, the good news is that a recent trend indicates that pregnancies are slowly declining in our state. Mississippians (educators, health care providers, religious leaders, civic leaders, public and private sectors, etc.), are working hard to educate, provide medical and other services, provide leadership and resources to help our young population make informed choices, and provide access to the best medical care. In addition, it has been recognized that the consequences of early childbearing are serious and predictable. Therefore, the issue is being addressed head on, and many parents of these young people are active participants.

Some commentators on this issue of teenage pregnancy contend that the problem is not really teenagers who want sex so soon, but it is our society that offers too little, too late - too little birth control information, too few job opportunities, and too little reason for many teenagers to stay in school and delay childbearing.[11]

The social conditions in Mississippi, like many other states, simultaneously promote and punish early childbearing. The relevant literature clearly suggests that if we are to change these conditions, then we must produce a better range of health, social, educational, and vocational strategies. However, to alter the choices of adolescents, adult priorities need to be redirected. If adults plan to help teenagers avoid the outcomes of sex that are clearly negative, they must first accept the reality of adolescent sexual activity. Also, they must deal with it directly and honestly.

Some selected facts about teenage pregnancy in Mississippi are presented here. The data paint the pictures of the young mothers in this state who are hardly removed from childhood themselves, whose education is incomplete parenting skills are undeveloped, and personal potential is unfulfilled. It also reveals the need for all of us to make a concerted effort to save the most valuable resource this state possesses, the children.

Birth Rates for the Top Ten States by Race* for Teens 15-19 (United States, 1992)

Total (All Races)			White			Black		
State	Rate	Rank	State	Rate	Rank	State	Rate	Rank
Mississippi	**84.2**	**1**	Arizona	79.9	1	Wisconsin	167.1	1
Arizona	81.7	2	New Mexico	79.5	2	Minnesota	162.6	2
New Mexico	80.3	3	California	79.3	3	Illinois	144.6	3
Texas	78.9	4	Texas	75.1	4	Missouri	143.9	4
Louisiana	76.5	5	Nevada	65.6	5	Iowa	137.7	5
Arkansas	75.5	6	Oklahoma	63.1	6	Kansas	137.4	6
Georgia	74.5	7	Arkansas	62.8	7	Nevada	137.2	7
California	74.0	8	Kentucky	60.7	8	Ohio	132.4	8
Alabama	72.5	9	Tennessee	58.5	9	Rhode Island	131.1	9
Nevada	71.4	10	**Mississippi**	**57.2**	**10**	Pennsylvania	127.3	10
Tennessee	71.4	10				**Mississippi**	**116.1**	**20**

* Birth rates for women of races other than white or black are not presented because the composition of this category varied widely by state

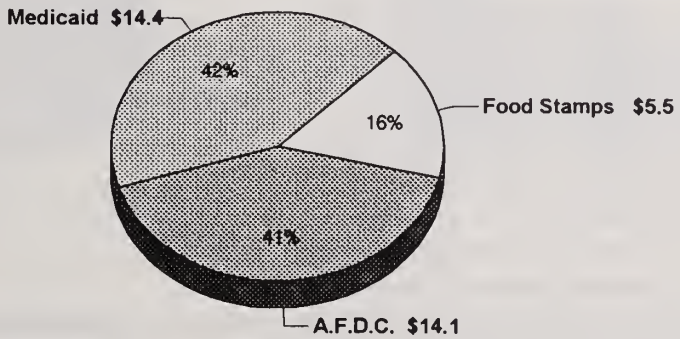
U. S. Department of Health and Human Services/Public Health Statistics

The Study

Teen birth rates vary due to the increase or decrease in births and the difference in the population's black/white ratio in each state. When rates are calculated from small numbers of observations, a greater variance in these rates exists. This effect is most severe when both the numerator (the number of events being studied) and the denominator (the number in the population being studied) are small. However, the effect can also be seen when the number of observations is small and the population is of moderate size.

For example, the states ranking in the top 10 for black teen births have only 15 percent or fewer blacks. Mississippi's total population is comprised of approxi-

Public Cost of Teen Childbearing in the United States, 1992

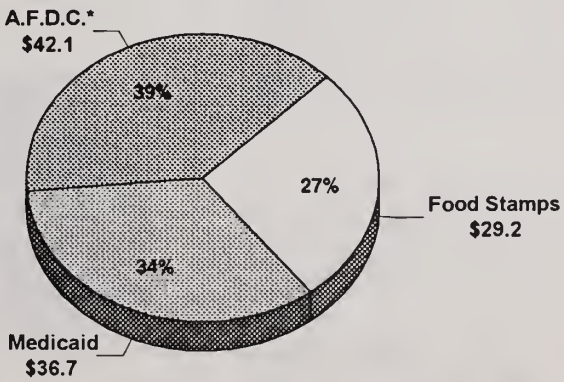


$34.4 Billion

*Aid to Families with Dependent Children

The amount spent this year for families that began when the mother was a teenager.

Public Cost of Teen Childbearing in Mississippi, 1994



$108.2 Million

*Aid to Families with Dependent Children

Mississippi State Department Of Health
Public Health Statistics

Center for Population Options,
Washington, D.C.

The amount spent this year for families that began when the mother was a teenager.

mately 36 percent black. In view of this, it is easier to understand why Mississippi is ranked twentieth for teen birth rates of blacks.

Data reveal that there is a slight yet constant decline in the number of pregnancies that occur to teens. The number has declined from 11,089 during 1992 to 10,962 in 1993. The decline has continued in 1994 to 10,802.

Approximately one-third or 2,843 of the 9,265 live births to Mississippi teens in 1994 were to teens who had already had at least one previous pregnancy. The birth marked the first pregnancy for 6,417, the second for 2,118, the third for 566, and the fourth or more for 159.

Mississippi's trend for teen births, as a percent of all live births, has shown only slight deviation from the national trend from 1974 through 1994. The trend for teen births in Mississippi has remained in line with the nation's. Our percentage of births to teens remains two-thirds higher, according to the 1992 statistics. Both began falling in 1975 and continued downward through 1987. Teen births increased slightly during 1988 and 1989 and have since remained fairly level. In 1993 Mississippi's births began rising once again.

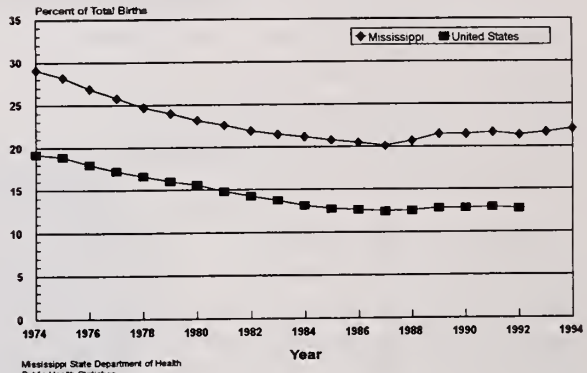
In Mississippi, while the total number of teen births steadily dropped through 1987, the number of births to unmarried teens remained constant, with only slight deviations. Consequently, each year a greater proportion of those teen births has been to unmarried mothers. In 1974, 46.7 percent of the teen births were to unmarried mothers. In 1994, unmarried mothers comprised 79.7 percent of the teen births. This sharp increase is primarily due to the significant increase of unwed white teen mothers. The number of teen births to unmarried white mothers has more than tripled in the past 20 years rising from 524 in 1974 to 1,586 in 1994. Births to unmarried black teens rose slightly from 5,458 in 1974 to 5,797 in 1994.

In 1994, Mississippi's teen mothers were 74.0 percent more likely to have babies die during the first year of life than adult mothers. The teen infant mortality rate in 1994 was 16.7 infant deaths per 1,000 live births to women less than 20 years of age. The corresponding rate for adults was 9.1 deaths per 1,000 live births to women 20-years-old or older.

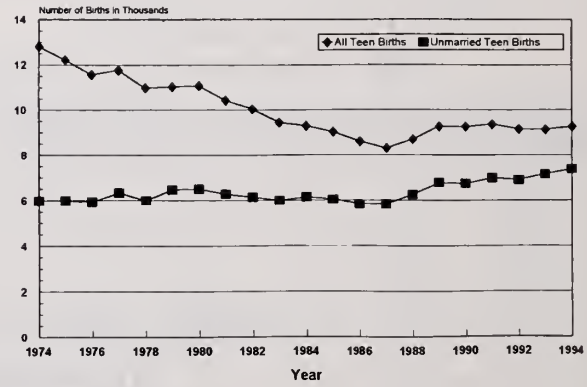
The risk of having an infant die was 121.0 percent greater for white teens than for white adults. In 1994, the infant mortality rate for white teens was 14.3 and for white adults 6.3.

Although the disparity of 38.4 was less between nonwhite teens and nonwhite adults, the infant mortality rate for nonwhite teens was 18.4 and 12.6 for nonwhite

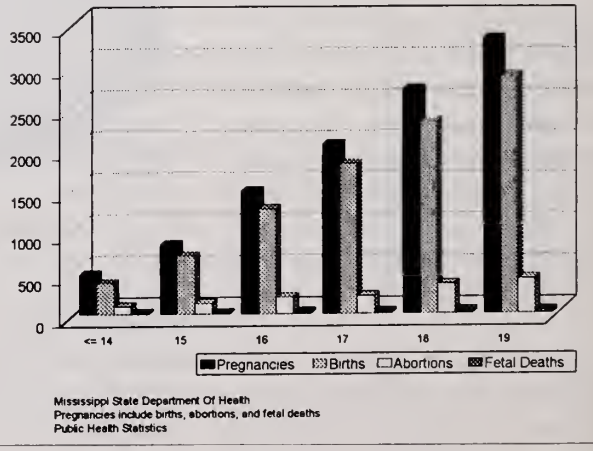
Percent of Births to Teens
Mississippi and the United States
1974 - 1994

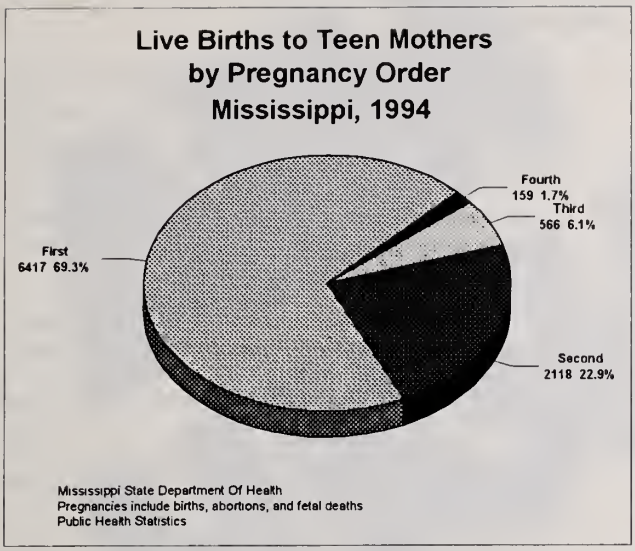


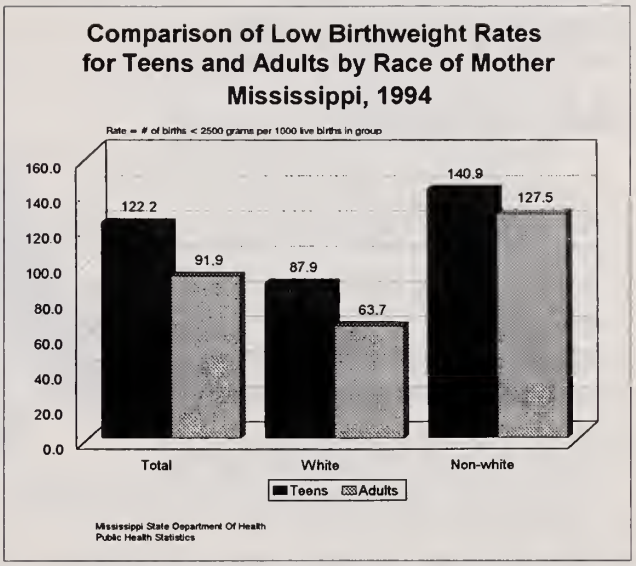
Comparison of All Teen Births
and Unmarried Teen Births
Mississippi, 1974 - 1994



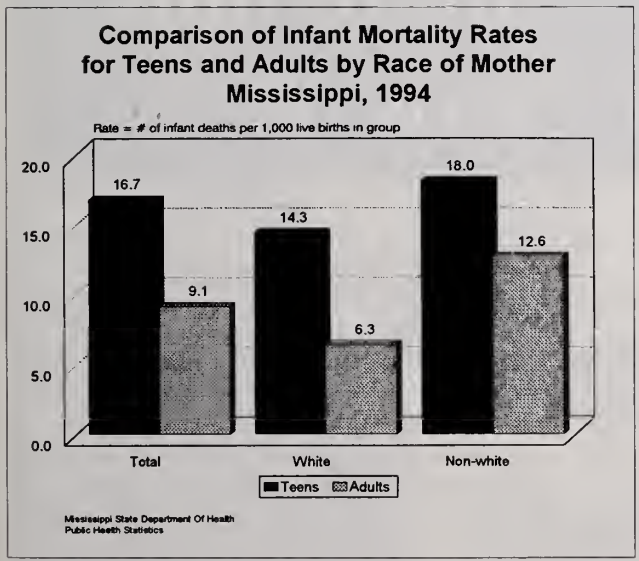
Pregnancies, Births, Abortions,
and Fetal Deaths for Teens by Age
Mississippi, 1994







Ages 11-19 Mississippi 1994	Age Of Mother								
	<11	12	13	14	15	16	17	18	19
Pregnancies	2	19	112	341	831	1,472	2,035	2,690	3,300
Births	1	16	79	274	694	1,252	1,798	2,304	2,847
Abortions	1	2	30	60	125	197	213	354	417
Fetal Deaths	0	1	3	7	12	23	24	32	36



adults. Low birthweight is one major contributor to the high cost of teen childbearing. It is also a major contributor to infant mortality.

The pattern for low birthweight rates is not as pronounced as for infant mortality rates, but the same adverse relationship exists. Teens overall and nonwhite more than whites have low birthweight babies (infants who weigh less than 2,500 grams or about five-and-one-half pounds.)

The low birthweight rate for teens was 122.2 per 1,000 live births compared with 91.9 for adults, making the rate for teens 33.0 percent higher.

The rate of 87.9 for white teens was 37.8 percent higher than that of 63.7 for white adults. The rate of 140.9 for nonwhite teens was 10. 5 perecnt higher than that of 127.5 for nonwhite adults.

Conclusions

Problem: Teen Pregnancy

One fifth of all newborns in Mississippi are born to teens. They are:

- More likely to be born to unmarried females.
- Less likely to get prenatal care before the second trimester.
- At higher risk of low birthweight.
- More likely to receive public assistance.

•At greater risk for abuse or neglect.
•More likely themselves to become teen parents.

Strategies: Preventing Teen Pregnancy

Most authorities on this subject conclude that the most effective interventions are:
•Health education with emphasis on postponing sexual activity.
•Teaching sexually active teens to practice effective contraception.
•Providing convenient access to high quality contraceptive services for sexually active teens.

Recommendations: Providing Services

Provide to those teens who do become pregnant such specialized services as:
•Convenient access to quality prenatal care services.
•Increased family planning efforts to prevent second births during the teen years.
•Job training to break the dependency on public assistance programs.
•Day care programs to enable teen parents to complete education and/or work.
•School nurse or school-based clinic services.

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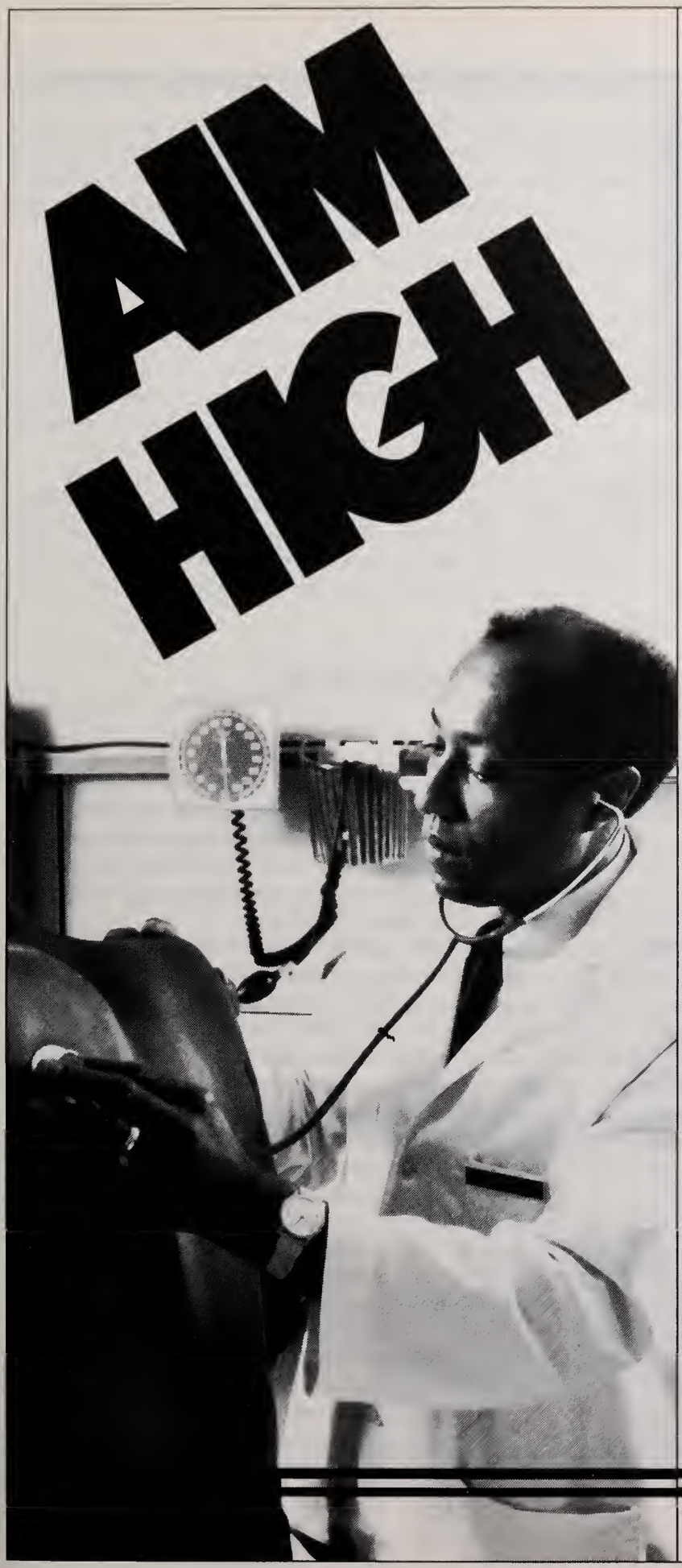
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Fred L. McMillan, M.D.

The President's Page

What's One to do?

These are frightening times for physician's and it is no wonder that we feel overwhelmed and confused. The most frightening change that can take place for someone is how payment for their services will be determined. The health insurance companies, after profiting heavily for their first fifty plus years from the combined dynamics of medical advancement, baby boomers, and Medicare, are now having to shift the financial risks to physicians and hospitals. Their scheme- *capitation*.

In addition, insurance companies, along with health plans and government programs, have created new layers of control over physicians trying to render the most appropriate care to their patients. On a national level, hospitals through their think tank, the Advisory Board, are advocating the creation of PHO's which can place hospitals into the business side of physician practice but not visa versa.

So how do we individually deal with these changes?

First, we can realize we have the power to control the health care delivery system because we will always be the point at which the patient is brought into the health care delivery system. Physicians are the ones most trusted to stand up for what is best for their patients; however, to effectively use this influence we must be sure that what we are advocating is for the best medical care at an affordable price. As in any industry the customer must come first - particularly in a service industry such as medicine since the patient is so vulnerable with their health care being entrusted to us.

Secondly, we must come together and deal with these changes collectively- getting past the primary care versus specialty care. There simply is too much on the line for us and the future generations of U.S. physicians. Collectively, we must identify and deal effectively with the waste, excess, and inefficiency in the current system. These are the changes that can help ensure that patients receive cost-effective care in the future.

Thirdly, nothing stays the same. Adapting to a changing system is difficult, but imperative. Physicians fought Medicare because of its potential for leading to socialized

medicine. In fact, it did allow greater access for a huge segment of the population and in the long run physicians themselves greatly benefited. Now, as the pendulum of change begins to swing back to less monies spent on medical care while attempting to maintain access for all patients, we must assert our leadership in assuring quality patient care and learn to deal with the new payment system. By doing so, we will continue to benefit from the change.

One of the ways we can do this is by associating with large groups of physician-owned networks.

Experience elsewhere has shown that the most effective competition for capitated lives comes from physician networks. Therefore, the question is, who is in control of these networks - entrepreneurs, insurance companies, hospitals, or physicians? Physician ownership means the difference between being a player or a pawn. These physician-owned networks should be modeled after the very successful physician-owned malpractice insurance companies; i.e., our own MACM. The profits are distributed to and, more importantly, policy is set by physician-owners. In the future, physicians must not succumb to the temptation to take the profits from selling the networks, nor to deviate from being the patient's advocate.

What is organized medicine doing to assist us individually in dealing with these changes?

The AMA is changing the federation to encompass more equal representation of all specialty areas, while lobbying for legislative and policy changes that allow physicians to compete equally with non-physician-owned HMO'S. Our MSMA has formed MPCN. Individually, we will need to support these collective efforts and delivery systems that are democratically controlled by physicians. Above all, our focus must be on patient advocacy by accepting nothing less than efficient and appropriate patient care.

Fred

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Editorial

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MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 2
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Lessons Patients Teach Us

Robert Fulghum said it best in his 1986 best-seller *All I Really Need to Know I Learned in Kindergarten,* "Wisdom was not there at the top of the graduate-school mountain, but there in the sandpile at Sunday School." Things like... "Share everything. Play fair. Don't hit people. Put things back where you found them. Clean up your own mess. Don't take things that aren't yours. Say you're sorry when you hurt somebody. Wash your hands before you eat. Flush. Warm cookies and cold milk are good for you. Live a balanced life- learn some and think some and draw and paint and sing and dance and play and work every day some. Take a nap every afternoon. When you go out into the world, watch the traffic, hold hands and stick together. Be aware of wonder. Remember the little seed in the Styrofoam cup: The roots go down and the plant goes up and nobody really knows how or why, but we are all like that. Goldfish and white mice and even the little seed in the Styrofoam cup-they all die. So do we. And then remember the *Dick and Jane* books and the first word you learned, the biggest word of all, LOOK. Take any one of those items and extrapolate it into adult terms and apply it to your family life or your work or your government or your world and it holds true."

I agree with the essence of what he's saying, that what is really important in life is acquired at our most basic level. To paraphrase Mr. Fulghum, I would add that "all I really need to know about medicine I learned from my patients." A University is a great starting point, but the medical school curriculum is a poor format for learning life-lessons. I suppose that deep-down in the nether world of our psyches, physicians share this fear that some how we will be discovered to be inadequate, that we simply don't know enough. That's probably why we say that we "practice" medicine, always seeming to come just short of the mark of a perfect out come. There are simply too many human variables. Periodically, I have this recurrent dream that some medical managed-care, big brother type, who's watching over me using satellites, computers and hidden cameras waltzes into my office and says, "There has been a mistake, you didn't learn enough in medical school. You are being sent back. Pack your bags." In this dream, the reasons why I have to go back are fuzzy, but the leaving home part and the moving back into the nursing dormitory in Jackson for four years is so vivid that I always wake up from this dream in a cold sweat before school actually even starts.

Our patients teach us plenty. In small town Mississippi, patients can be a veritable walking, talking textbook of pathophysiology. There are just too many examples to mention here. Any one of us could write a book on the subject.

One area that I believe is especially weak in the University setting is dermatology. I guess they figure people don't die from rashes, but there sure as heck are some moles that will kill you. And I guarantee you that 95 % of the patients that come to your office (for whatever reason) will ask you to identify and/or treat at least one lesion before they leave. In my case I'm asked to inspect at least two patient's "hickeys or doodads" every time I go to Wal-Mart. But, that's perfectly okay because I've come to realize that every patient I see teaches me a lesson about medicine.

A few weeks ago I received a short course in skin disorders from a young woman who was affected with several epidermal ailments. Lucky for me, she was well-versed in them and primarily wanted refills on the creams she had received from her dermatologist back in California. She rattled off her different diagnoses and I braked when she said she had "a classic case of dermatographism." "Show me," I said. She instructed me to take my fingertip and trace something on her skin, then sit back and watch for a bit. Having just seen a rerun of the "Exorcist" on TV, I gingerly wrote "Help me!" with my index finger across her back. In less than three minutes I was standing in the exam room looking at "HELP ME!" written in bold, red whelps on this girl's back. I remember saying "ooooh" or "wow" or something equally inappropriate, having been reduced to the pupil of my patient. But, thanks to her I will never forget what dermatographism is.

Nutrition is another weak point in the medical school curriculum, yet in actual practice we are called upon to

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prescribe some special diet to almost every patient we see. The patients will educate you over the years through trial and error. For instance , it is one thing to tell a Southerner to eat a low-residue diet, it is quite another to instruct them on how to accomplish this. One sweet lady that I treat for horrible bouts of diverticulitis was resourceful enough to come up with ways to cook things she could eat without sending her gut into a tailspin. She has shared her recipes with me which I in turn give to others who are "colonically-challenged." The most useful has proved to be her "colon-friendly cornbread" recipe which calls for Cream-of-Wheat instead of corn meal. It's pretty darn good actually.

These examples are superficial, but you get the idea. Patients can also teach us lessons we can apply to our own lives.

People having domestic difficulties have taught me the aphorism "there are two sides to every story" is simply not true. The truism is that there are as many sides to a story as there are people involved in it. There may be seven or eight sides to the picture that is being painted to you by only one person. The point is to try not to take sides in family feuds. It will come back to haunt you. This was a hard lesson for me to learn and sometimes I realize I still haven't mastered it....especially when children are involved.

Many times we send people elsewhere to get help that we are either unable or unwilling to give. Later they come back and share with us what they've learned. I never really knew much about what people did at A.A. meetings or any of those other "Twelve-Step" programs. When successful, these folks can teach you worlds of valuable lessons. One that comes to mind now is that "if we act the way we'd like to be, we will soon be the way we act." Put more succinctly, "fake it until you make it."

Also dealing with these addictive personalities has helped me to learn tolerance and acceptance. The majority of people are doing the best they can with whatever resources they have. If they didn't want help, at least at some level, they wouldn't be at your doorstep. Try to accept patients (and everybody else) "as is." If people could be any different, they would be.

My Grandpa, while dying of esophageal carcinoma told me something years ago that has always stuck with me..."Remember girl, your health is the most important asset you have in this world, and when you lose it you've lost it all. Shrouds ain't got no pockets."

He was right. People (doctors included) never appreciate their health until they've begun to lose it.

My great uncle, also a patient, gave me a bittersweet insight a few years back..."My dear, there is only one fair thing in this life, and it comes to town once a year in August." I have learned, as have you, that life is not fair. It isn't fair when an 18-year-old dies in a wreck on his way home from a high school graduation party, or when a young mother-of- two develops colon cancer.

Patients and their families teach us to accept the hand we are dealt, and to play it the best way we can.

I'm learned from watching people over the years that the older we get, the more like our true selves we become. A person who is considered an eccentric or unique individual at age 30 is likely to be thought of as a senile old biddy at 75.

Personally, I plan to enjoy being able to be completely tactless and say exactly what I think to people when I'm 70 or so. They'll say, "Don't mind her, she's just old and crazy." But I'll know better.

I've learned that people can grow old gracefully and you can die with dignity, though many choose not to.

I've learned that the best prayers are the little ones, those prayed "on the hoof" so to speak. I say a little prayer every time I order a penicillin shot.

I've learned never to say, "I don't know" when someone asks me a question. I say, "I don't have the answer yet, but you and I will find out." It is truthful and soothes many a jangled nerve.

I've learned from patients not to take responsibility for things I can't control. You can empathize with someone's pain and frustration without accepting responsibility for it. You are not responsible for creating a person's disease process. We should accept responsibility only for what we can control, our own behavior.

I've come to understand that truly caring for our patients is the sum and substance of what doctors are put on this earth to do and we should never lose sight of that fact. When you do, when on more days than not you go to the office and feel resentment for the wants and needs of your patients, that is a signal that you need a vacation, a real one. Take it.

We are not indispensable, most folks would get better with or without us. The majority of what we do is simply making people's lives a little more tolerable and slightly more pleasant than they would otherwise be.

There are so many lessons to be learned. We'll stop on this one....I've learned that the three sweetest words a physician can ever hear uttered are, "Thank you, Doctor." **-Dwalia South, M.D., Associate Editor**

Trends in the Physician Services Market

Recent results from the American Medical Association's Socioeconomic Monitoring System surveys indicate several interesting trends in the medical practice marketplace.

Median physician net income (after expenses, before taxes) increased 6.7% in 1995, offsetting a 3.8% decrease in the past year. These opposing results for the two years illustrate the danger of drawing long-term conclusions based an change in one year alone. (The statistics in this report are for nonfederal patient care physicians, excluding residents.)

The two-year change in income amounts to an average annual increase of 1.3% from 1993 to 1995, which, when adjusted for inflation represents an average annual decline of 1.4% in real income. Since 1992, median income increases have averaged 2.2%, below the inflation rate of 2.8%.

For comparison purposes, national health expenditures increased an estimated 6.1% in 1994, according to the Health Care Financing Administration.

The long-term trend away from self-employment and toward employee status continued in 1995. The proportion of employee physicians grew from 36% to 39%. Nearly all of these additional employees came from the ranks of self-employed physicians, whose market share dropped to 55% from 58%. Since employees generally earn less than the self-employed, the trend is one that would tend to restrain increases in average physician income. The percentage increase in income for self-employeds was greater than the increase for employees in 1995.

Incomes of self-employed physicians are nearly 50% higher than those of employees. Part of the differential is a return on entrepreneurship, investment, and risk taking, over and above compensation for providing physician services. A differential is necessary to attract capital to any enterprise. Other factors contribute to the differential. For instance, self-employeds tend to be older, have more years of experience, work more hours, and are more likely to be board certified, all of which are associated with higher earnings. Controlling for these factors, the income differential due solely to employment arrangement would be much less than 50%.

Three-fourths of employee physicians receive noncash benefits in addition to their reported income, whereas some self-employed physicians do not. These benefits are about 5% of income for employees. Therefore, a comparison of total compensation would show that the differential would be narrower than one based on cash income alone.

Income varies considerably from one specialty to another. In 1995, average income was lowest among general/family practitioners and pediatricians and highest for radiologists and surgeons, among the specialties examined separately.

The change in income from 1994 to 1995 varied substantially across specialties. Primary specialties generally enjoyed incomes that were greater than the average for all physicians; the exception was the broad category of internal medicine, for which median income was unchanged. Increases for surgical specialties were below the all-physician average. Pathology had the largest percentage increase in 1995, but that followed a year in which it had the largest decrease.

Managed care contracting increased markedly. In 1995, 83% of physicians had contracts with managed care organizations, compared with 77% in 1994. Further, the share of revenue from those contracts (among physicians with contracts) declined slightly, from 34% to 33%. How

these events correlate with changes in net income is a subject of continuing research. It is safe to say, however, that managed care is not the only, nor necessarily the most important, factor affecting income changes from year to year.

Published research suggests that "managed care has shifted the demand for physician services toward primary care providers, while reducing utilization fees for physicians." (Simon and Born, "Physician Earnings in a Changing Managed Care Environment," *Health Affairs,* Fall 1996). These findings are consistent with income patterns by specialty discussed here.

Income tends to vary less across geographic regions than specialties. Nevertheless, some notable variations occurred for 1994-1995 changes in income. Incomes were highest for physicians in the northeast, unchanged for those in the central states, and about average for those in the south and west.

While median net income represents what the doctor at the 50th percentile earned, the distribution of physician income is very wide and many fall far below that figure. For example, among physicians, one-fourth made $95,000 or less, compared with the median of $129,000.

Physician Earnings in Context

Physicians typically begin practicing between the ages of 26 and 35. In 1995, the average age of a medical school graduate was 29. Counting postgraduate education, many physicians are in their early thirties before starting to practice.

Residencies can last up to eight years. Residency pay is low, the median stipend for 1994-1995 is about $33,000, and yet residents work an average of 80 to 100 hours per week.

Most physicians incur high educational debt by the time they begin to practice. Seventy-nine percent of 1994 graduates reported some level of debt, with the average for those with indebtedness amounting to $63,885.

Physicians work longer hours than is typical in the labor force. The average number of hours spent in professional activities per week by physicians was 56.7 in 1995, about 42% more than the typical 40-hour week.

About the Survey

Information on medical practices is collected in an annual survey, the Socioeconomic Monitoring System (SMS). The survey sample is drawn randomly from the AMA's Physician Masterfile. Responses are obtained through telephone interviews of approximately 4,000 physicians. The statistics are weighted to adjust for survey nonresponse bias to improve the precision of estimates of income for the entire physician population. Both office- and hospital-based physicians are included. Nonmembers of the AMA are included in addition to AMA member physicians. Specialties are self-designated. All medical practice information is self-reported. Self-employeds are full or part owners of their practices. Net income is defined as income after expenses before taxes. Income comprises all earnings from medical practice, including fees, salaries, retainers, bonuses, and deferred compensation.

For the purposes of the SMS, a "physician" is defined as a nonfederal, post-resident MD involved typically in at least 20 hours per week in patient care activities. Roughly two-thirds of the nation's 720,325 physicians fall into this category. More than 200,000 lower-earning resident, non-patient-care, federal, and inactive physicians are excluded from these statistics.

Source: AMA Socioeconomic Monitoring System 1995 and 1996 core surveys of nonfederal patient care physicians excluding residents.

Rahul Vohra, M.D., Michael Winkelmann, M.D.
and Stuart Yablon, M.D.
are pleased to announce that

David C. Collipp, M.D.

has joined their practice

Dr. Collipp is board-certified in physical medicine and rehabilitation and is on the staff of Mississippi Methodist Rehabilitation Center

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Mississippi Hospital & Physician Foundation 1997 Health Issues Forum and Legislative Reception

The Mississippi Hospital & Physician Foundation 1997 Health Issues Forum and Legislative Reception was held January 15, 1997 at the Downtown Harvey Hotel in Jackson. Jointly sponsored by the Mississippi Hospital Association and the Mississippi State Medical Association, the event was well-attended by hospital administrators, physicians, and other members of the health care and business communities who came together to share information and develop policies that will allow us to deliver the best in high-quality, affordable health care to Mississippians.



Dr. Dewitt Crawford, Peggy Crawford *and* ***Representative Bobby Moody*** *of Louisville. Representative Moody is Chairman of the House Public Health and Welfare Committee.*



MSMA Executive Director ***Charles Mathews, Dr. Gerald Gable*** *of Hattiesburg,* ***Representative Dick Hall*** *of Jackson,* ***Patsy Gable***



Representative Charlie Williams *of Senatobia, Chairman of the House Ways and Means Committee;* ***Dr. Mitch Massey*** *of Tupelo*



Representative Rita Holden *of Grenada and* ***Dr. Don Mitchell*** *of Jackson*



Representative Mike Chaney, *left;* ***Dr. Chester Masterson*** *of Vicksburg, right and* ***Dr. Randy Easterling*** *of Vicksburg, center*



MSMA President Dr. Fred McMillan *of Jackson and* ***Representative Rita Holden*** *of Grenada*

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Health Promotions Spotlight



EAST MISSISSIPPI MEDICAL ALLIANCE- *Iris Boggan of the East Mississippi Medical Alliance (EMMA), along with her husband, Dr. Austin Boggan and a medical student from the University Medical Center, presented EMMA's first Tar Wars program of the year. The program was presented in September to classes of 5th graders at Newton Elementary School. Tar Wars is an anti-smoking program designed for 5th graders. Students participated in activities designed to emphasize the harmful effects of smoking as well as the benefits of not smoking. Other Tar Wars programs are planned over the state in the coming months.*

CENTRAL MISSISSIPPI MEDICAL ALLIANCE- *During Breast Cancer Awareness month, programs were presented in the female dorms at Mississippi College. The breast model was set up and students were given an opportunity to examine the model and ask questions. Information pamphlets and shower cards were given to the girls.*



NORTH CENTRAL MEDICAL ALLIANCE- *Alliance members Nell Middleton and Courtney Stanback presented an informative program on breast cancer awareness to students at Winona High School on October 30. Nell and Courtney report a wonderful response to the program. Much work went went into the planning of this seminar. Mayor Sonny Simmons presented a proclamation from the city in recognition of Breast Cancer awareness month. Also, at the November meeting of the North Central Alliance, members brought zip-lock bags filled with personal care items to be given to the Women's Abuse Shelter.*



A Haunted Evening Under the Oaks Aids Domestic Violence Shelter

The Singing River Medical Alliance and the Singing River Medical Society recently held "A Haunted Evening Under The Oaks" benefiting the Jackson County Domestic Violence Shelter. Guest were greeted by ghosts swaying in the trees, eerie sounds and bubbling caldrons. Dr. and Mrs. Edgar W. Hull hosted the October 29th event at the Chastant-Fuselier House in Pascagoula. Guests strolled along the gallery of the antebellum home bidding on silent auction items contributed by local artists and businesses. Others enjoyed dancing under the moss covered oaks to the music provided by Dr. William T. Avara and company. With over a hundred in attendance dressed in either costume or black tie, the benefit raised in excess of $8,000 to be given to the Salvation Army's Domestic Violence Shelter. Across the nation, AMA Alliances are adopting shelters for battered spouses and their children and are increasing awareness about domestic violence.



Mr. and Mrs. Bill Moore (Kay)-Cruella DeVille and Dracula,
Dr. and Mrs. Joe Pedone-The Invisible Man and Invisible Woman



Dr. and Mrs. Rick Whitlock (Maura)-Morticia and Gomez Adams



Dr. and Mrs. Hal Moore (Melanie)-Bride and Groom,
center, Mrs. Kathie Keene-Glenda, the Good Witch of the North



Dr. and Mrs. Mark Lyell-Priscilla and Elvis Presley



Mr. and Mrs. Bill Moore (Kay)-Cruella DeVille and Dracula
Mr. and Mrs. Arnie Moore (Sue)-Scarlett and Rhett

Telemedicine Is Becoming A Reality in the State

Methods of medical practice are continually evolving; we have only to read any recent literature to note the growing complexity of medical care and the increasing need for collaborations among health professionals and health care institutions. Rare are the days of the lone physician, equipped with personal expertise and experience for decision tools.

Many physicians today are members of medical groups, health maintenance organizations and preferred provider organizations, as technological and economic changes affect health care as never before.

One new technological development offering a potential savings in health care costs and resources is telemedicine, the interactive audiovisual communication between health care providers and their patients. Telemedicine can effectively reduce costs of traditional medicine. First utilized in 1959 when x-ray images were transmitted across telephone lines, telemedicine technology since that time has advanced, making it more affordable and clinically useful.

We can see that the future has arrived in the prediction that practicing physicians may be provided with the subspecialist expertise, thus allowing the patient to receive consultations in his or her local hospital.

In Mississippi, telemedicine is fast becoming a reality. A recent news release from Tupelo noted that the Rural Utilities Service (RUS) of the U. S. Department of Agriculture has awarded a $336,124 grant to North Mississippi Health Services to create a telecommunications network. North Mississippi Health Services (NMHS) was one of 29 recipients selected nationally to receive RUS funding and will use the grant money to fund the first phase of a distance learning and telemedicine program.

"The grant will enable NMHS to provide area residents, especially those in the most rural areas where the number of health care providers is limited, with access to quality health care," said Dr. Jeffrey B. Barber, NMHS president and chief executive officer. "We are not planning to use telemedicine as a substitute for physicians and other primary health care providers. We plan to use it as a means to support providers in their work," he added. The RUS funding will be used to establish telecommunication hub subsites at Iuka Hospital and to build the base for the system, which will be headquartered at North Mississippi Medical Center (NMMC). The system is designed to be totally interactive, where information can be received and transmitted via video, audio, fax and computer.

NMHS has established a long-range plan in five phases to establish a telecommunications network that would link all of the community hospitals, clinics and other services within its corporate system. The regional health care system will seek additional RUS funding and grants from other sources to finance the remaining four phases.

This technology will enable a physician in one community to consult with another via video-

conferencing. A primary care physician in Eupora could consult with a specialist in Tupelo by telecom while the patient is present. Both patient and physicians could question the specialist and possibly avoid travel expenses for the patient. Phases two through five of the project would be the establishment of telecommunication hub subsites throughout the area, then expanding the system into other aspects of the NMHS regional health care delivery system and finally including placement of interactive monitors in the homes of acute patients under the care of NMMC Home Health Agency.

The technology available now allows for a spectrum of capabilities. Still pictures over a telephone line augmented by direct verbal communications are presently user-friendly, economical and have a proven utility in the pre-hospital care arena. The compressed audiovisual technology allows direct and instantaneous visual and audible interaction with the patient.

Auscultation, visualizing tympanic membranes and fundoscopic exams can be performed accurately and in real time.

Telemedicine may become another tool used by the clinician to access patient charts, lab work, EKGs, and x-rays.

The military has been using telemedicine in Croatia and Somalia to help treat the injured and the sick. Investments include a reported $70 million in developing this technology. Private industries are investing up to $1 billion in developing advanced communication technology. Some 13 federal agencies and 40 states are involved in setting up the infrastructure to make telemedicine accessible, cost effective, user-friendly and clinically useful. University and hospital systems are already using it for medical consulting, medical education and pre-hospital care.

Telemedicine has uses which vary widely, including industrial use on oil rigs and cargo ships. Injured or ill workers can have treatment initiated while waiting for transportation to a hospital. This decreases the delay in their acute medical treatment.

Telemedicine has been available for medical consultations during natural disasters such as earthquakes. University hospitals are providing second opinions and continuing medical education to community hospitals as far away as the Middle East.

This technology represents a means to make the health care system much more user-friendly and allow for a truly integrated system.

-James S. McIlwain, M. D.
Principal Clinical Coordinator



New Members

BAILEY, JOHN D., Pascagoula. Born April 3, 1965, Madison, AL. MD University of Alabama School of Medicine, Birmingham, AL, 1991; general surgery residency, 1992-96 same; elected by Singing River Medical Society.

BROADRICK, GARY LEE, Houston. Born June 28, 1942, Dalton, GA; MD Emory University School of Medicine, Atlanta, GA, 1968; interned one year, same; general surgery residency, US Naval Hospital, Boston, MA, 1969-73; elected by Prairie Medical Society.

ELLIS, MARK L., Brookhaven. Born March 3, 1965 Mobile, AL; MD University of Mississippi School of Medicine, Jackson, MS, 1991; diagnostic radiology residency, University Medical Center, Jackson, MS, 1991-96; elected by South Central Medical Society.

FOSTER-GALBRAITH, PAULETTE L, Pass Christian. Born January 15, 1967 in Houston, TX; MD University of Texas Health Science Center, San Antonio, TX 1992; interned and family practice residency, same, 1992-95; elected by Coast Counties Medical Society.

GELFAND, STEPHEN G., Tupelo. Born September 21, 1942, Brooklyn, NY; MD Albany Medical College, Albany, NY 1968; internal medicine residency , Long Island Jewish Medical Center, New Hyde Park, NY, 1968-71; rheumatology fellowship, University of Tennessee Medical Center, Memphis, TN, 1973-74; elected by Northeast MS Medical Society.

HADDON, W. SCOTT, Clarksdale. Born May 29, 1959, Canada; MD University of North Carolina School of Medicine, Chapel Hill, NC, 1985; general surgery residency, State University of New York, Buffalo, 1985-92; vascular surgery residency, University of North Carolina Medical Center, Chapel Hill, NC, 1994-95; elected by Clarksdale & Six Counties Medical Society.

MATTHEWS, JAMES C., III, Meridian. Born October 6, 1965, Birmingham, AL; DO Kirksville College of Osteopathic Medicine, Kirksville, MO, 1983; family practice residency, University of Alabama Medical Center, Selma, AL, 1993-96; elected by East MS Medical Society.

McMILLAN, TERRY Y., Greenwood. Born October 14, 1959, Ripley, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1991; one year internship, Erlanger Hospital, Chattanooga, TN; ob-gyn residency, University of Tennessee Medical Center, Chattanooga, TN, 1992-96; elected by Delta Medical Society.

MONAJJEM, NAVID, Indianola. Born December 1, 1965, Amsterdam, Holland; MD Ohio State University College of Medicine, Columbus, OH, 1991; general surgery residency, University Medical Center, Jackson, MS, 1/91 - 12/96; elected by Delta Medical Society.

MURCKO, LISA C., Hattiesburg. Born April 14, 1961, Fairborn, OH; MD Medical College of Pennsylvania, Philadelphia, PA, 1988; interned, Oshner Foundation Hospital, New Orleans, LA, 1989-90; fellowship in Hand/Microsurgery, Medical Center of LA (Charity) 1990-91; general surgery residency, same, 1991-92; plastic surgery residency, Medical Center of LA (Charity Hospital), New Orleans, LA, 1992-94; fellowship in general/breast surgery, Charlotte Hospital, Charltote, NC; elected by South MS Medical Society.

SHAMSI, ZIAUDDIN, Pascagoula. Born April 10, 1947, Agra, India; MD Liaquat Medical College, Pakistan 1971; internal medicine residency, University of Pennsylvania Medical School, Philadelphia, PA, 1973-76; gastroenterology fellowship, same, 1976-77; elected by Singing River Medical Society.

SIDDIQ, ZUBAIR A., Hattiesburg. Born January 10, 1964, Lahore, Pakistan; MD Dow Medical College, Karachi, Pakistan 1987; interned one year same; internal medicine residency, St. Luke's Medical Center, Cleveland, OH 1992-95; elected by South MS Medical Society.

SOUED, MOUNZER, Iuka. Born July 27, 1961; MD Aleppo Medical School, Syria, 1985; internal medicine residency, University of Tennessee Medical Center, Memphis, TN, 1990-93; gastroenterology fellowship, same, 19993-96; elected by Northeast MS Medical Society.

TERRY, COOPER L., Oxford. Born October 15, 1963, Jacksonville, FL; MD Vanderbilt University School of Medicine, Nashville,

TN, 1989; orthopaedic surgery residency Duke University Medical Center, Durham, NC, 1989-95; fellowship, Hand and Upper Extremity Surgery, Harvard, Boston, MA, 1995-96; elected by North MS Medical Society.

WILLIAMSON, TERESA A., Pascagoula. Born September 9, 1960; MD University of Mississippi School of Medicine, Jackson, MS, 1987; family practice residency, University Medical Center, Jackson, MS, 1987-90; elected by Singing River Medical Society.

DEATHS:

HAUSER, FRED W., Murfreesboro, TN. Born October 27, 1920, Rives, TN; MD University of Tennessee Medical School, Memphis, TN 1944; interned one year, John Gaston Hospital, Memphis, TN; obgyn residency, Ravenswood Hospital, Chicago, IL, 1946 and John Gaston Hospital, Memphis, TN, 1947-48; died October 14, 1996 age 76.

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Personals

David P. Smith, M.D., has been recognized for his contributions to community service by the American Medical Association. Dr. Smith is a resident of the University of Mississippi Department of Family Medicine. He was one of 40 honorees of the AMA/Glaxo Wellcome, Inc. Leadership Award Program for resident physicians. Dr. Smith attended the Interim meeting of the group in Atlanta, Georgia last December. During medical school Dr. Smith founded the Christians' United American Family Association in McComb and currently serves as president of the association which has grown to over 1,200 members. He has been on the board of directors for the American Family Association of Mississippi.

Walter T. Boone, M.D., Roland F. Garretson, Jr., M.D., Thomas P. Mills, M.D. and **Deborah S. Skelton, M.D.** announce the relocation of the Digestive Disease Clinic to Suite 515, 971 Lakeland Drive, Jackson, Mississippi, 39216.

Jeffrey M. Evans, M.D., F.C.C.P., A.C.P, has been bestowed the prestigious honor of Fellow by the American College of Chest Physicians. Dr. Evans is a pulmonologist with Baptist Memorial Hospital North Mississippi. He is also the coordinator of Baptist Memorial Hospital North Mississippi Sleep Lab. As a Fellow, Dr. Evans will play an active role in assisting the organization with maintaining and advancing high standards of medical practice in cardiopulmonary medicine, surgery, critical care and related disciplines. Dr. Evans' specialities include pulmonary medicine, critical care and sleep disorders.

William E. Studdard, Jr., M.D. has been named as a fellow of the American College of Radiology. Selected for his contributions to the field of radiology, Studdard was named as one of 142 new fellows by the College's Board of Chancellors.

Stephen C. Lambert, M.D. has moved his family practice to The Family Practice Clinic joining Drs. Terry Lowe, Michael May and Wayne Hughes. Dr. Lambert had been previously practicing at the Seminary Health Clinic.

Robert H. Middleton, M.D., of Biloxi, retired from medical practice December 31, 1996.

John A. Marascalco, M.D., dermatologist, announces the relocation of his practice from Greenville to Grenada, Mississippi. His address is 965 Avent Drive, Suite 100A, Physician Office Building, Grenada Lake Medical Center.

Steven W. Stogner, M.D., a pulmonary and critical care physician at Hattiesburg Clinic, recently spoke about current medical issues at two medical conferences in the Southeast. He spoke to the Central Mississippi Advanced Nurses Group about treatment for community acquired pneumonia. He also gave a presentation entitled "New Horizons in Health Care Delivery" at Louisiana State University Medical Center in Shreveport, Louisiana. Stogner joined Hattiesburg Clinic in July 1992. He is a graduate of the University of Mississippi Medical School.

D. Rodney N. Lovitt, M.D., a family practice physician at Petal Family Practice Clinic, a service of Hattiesburg Clinic, successfully completed the American Board of Family Practice recertification examination. Lovitt received his medical degree from the University of Mississippi School of Medicine in Jackson. He then completed an internship and residency in family practice at the University of Mississippi Medical School. Lovitt is a diplomat of the American Board of Family Practice and a member of the American Academy of Physicians.

Crystal L. "Chris" Tate M.D. has been named an assistant professor with North Mississippi Family Medical Center's Family Medicine Residency Program. Dr. Tate, who joined the program's faculty this month, previously worked at Saltillo Family Medical Clinic, one of the regional primary care clinics operated by North Mississippi Family Medical Clinics. NMMC's Family Medicine Residency Program is affiliated with the University of Mississippi Medical Center in Jackson.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

The program is a three-year program with the first year of training at UMMC and the second and third years at NMMC.

Dominic Trinca, M.D., obstetrician and gynecologist, has recently fulfilled all requirements to be a certified Diplomate of The American Board of Obstetrics and Gynecology; that is, he is Board Certified. Dr. Trinca completed his Bachelor of Science at St. John's University College of Pharmacy. He continued his education at St. George' School of Medicine and Albany Medical College.

Keith Thomae, M.D. was among 1,661 initiates from around the world who became Fellows of the American College of Surgeons during convocation ceremonies at the College's recent annual Clinical Congress in San Francisco. Dr. Thomae received a medical doctorate in 1988 from the University of Wisconsin and is currently practicing at the University Medical Center. In 1994, Dr. Thomae received board certification from the American Board of Surgery. Dr. Thomae has a strong professional interest in Trauma, and holds memberships in other professional societies, including the Eastern Association for Surgery of Trauma, Southeastern Surgical Society Society of Critical Care Medicine, AMA, MSMA and the Shock Society.

Thad Waites, M.D. has been named medical director of Forrest General Hospital's cardiac catheterization laboratory. Dr. Waites is a staff cardiologist affiliated with Southern Heart Center, a division of Hattiesburg Clinic. A member of the FGH Medical Staff since 1987, Waites is also past president of the medical staff. He is a graduate of the University of Mississippi School of Medicine. He completed his internship and residency at Grady Memorial Hospital in Atlanta and the University of Colorado. He served as chief resident of cardiology at Emory University Hospital in Atlanta. Before joining the Medical staff at Forrest General, he was a staff cardiologist at Oschner Clinic. Dr. Waites is board certified in internal medicine - cardiovascular disease and sub-specializes in invasive cardiology. He is a fellow of the American College of Cardiology, the American Society of Pacing and Electrophysiology and the Society of Cardiac Angiograghy. The hospital's catheterization laboratory is a service of Forrest General's Cardiac Center of Excellence. The "cath" lab provides facilities for performing various diagnostic and interventional catheterization procedures, including angio-plasty, atherectomy, rotoblator and electrophysiology studies.

Sidney 0. Graves, M.D. was the subject of a lead article in the Natchez Democrat upon the recent announcement of his retirement after 44 years of practicing medicine in that community. The article noted Dr. Graves' service to the community, as president of MSMA, a member of the Mississippi State Board of Health and delegate to the American Medical Association for the past 14 years.

Ralph L. Brock, M.D.; Benton Hewitt, M.D.; Verner Holmes, M.D.; his brother, **Wendell B. Holmes** and **William T. Mayer, M.D.,** with a combined 206 years in medical practice, earned recognition from South Mississippi Regional Medical Center officials. The hospital's trustees honored during their monthly meeting. Each received a plaque recognizing his service to the hospital and the medical field. All are retired from duty at the hospital but have not given up medical practice for good.

James Hardy, M.D., professor emeritus of surgery, is being featured in one of the four-part programs in the series called, "Knife to the Heart," which began January 27 on Mississippi ETV. The series, hosted by Connie Chung, is a history of transplant surgery. Dr. Hardy, who headed the team that performed the world's first heart transplant at UMC, will be featured on the final program on February 17. The London film company, Barraclough Carey Productions Limited, produced the series and sold it to WNET. The film company producers spent two days filming in Jackson and at the Medical Center and interviewing Dr. Hardy.

Gerry Ann Houston, M. D., medical oncologist with Jackson Oncology Associates and Medical Director of Hospice of Central Mississippi, passed the Certification Examination for Hospice and Palliative Medicine.

Editor's Note: The 1994-1995 MSMA president and speaker were inadvertently omitted in the January 1997 JOURNAL MSMA article, "From 'Doc' on Horseback to Managed Care- In Commemoration of the 140th Anniversary of the Mississippi State Medical Association." They should have appeared at the top of page 904. The 1994-1995 president was **Mallon G. Morgan, M.D.** of Natchez; **H. Vann Craig M.D.** of Natchez, speaker. The Association met May 11-15, 1994 at the Ramada Plaza in Jackson.

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Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

❧ Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.

❧ Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.

❧ Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction premium for the hospital, bu there is much more that the physician should consider th just the bottom line," Hill ad "I was not willing to give up t benefits I receive through a physician-owned company lik Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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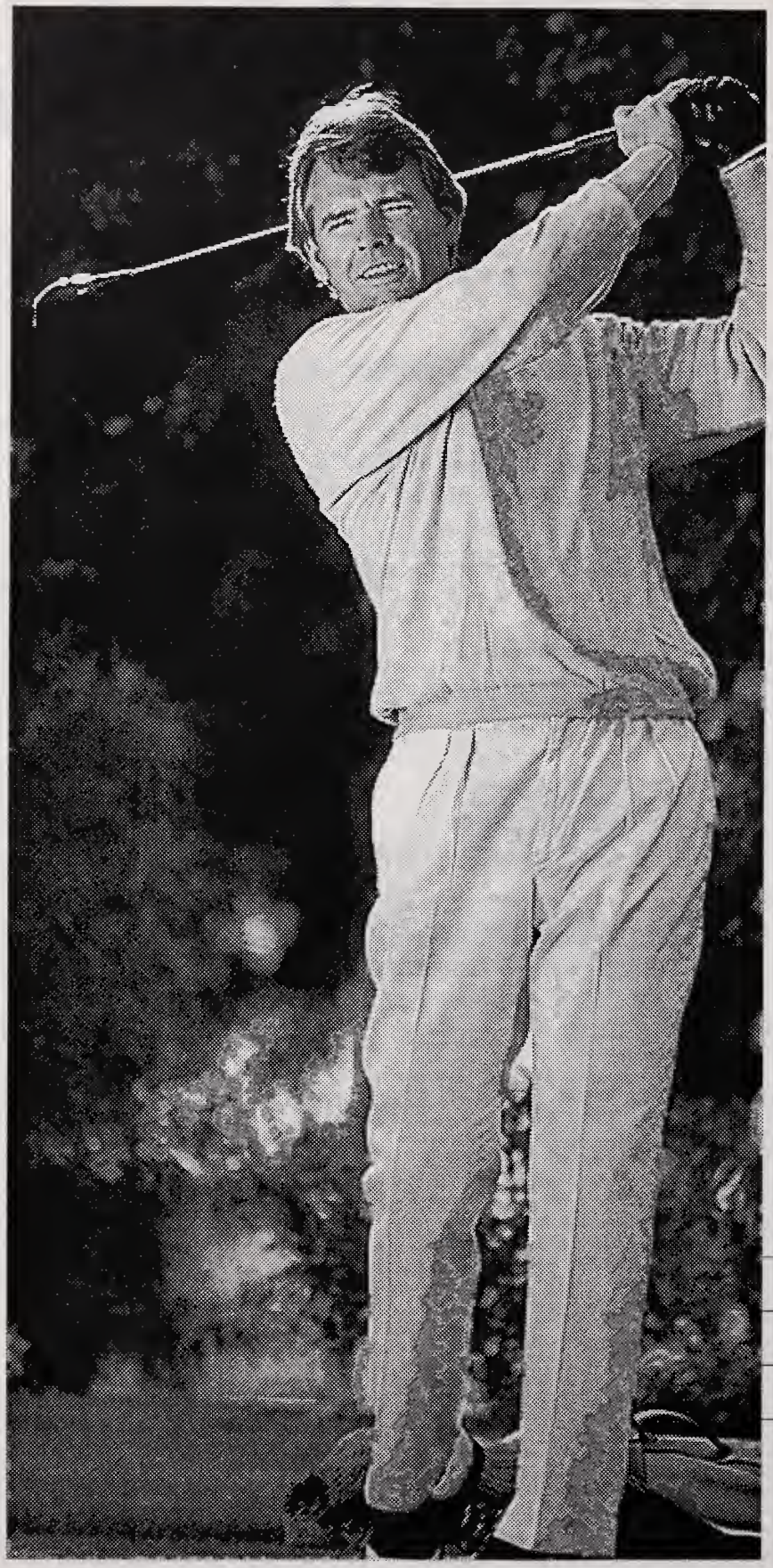
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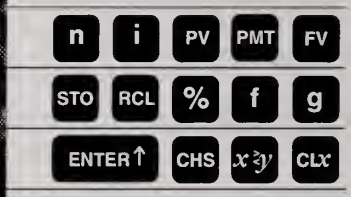
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Medical Computing in Mississippi

Richard L. Summers, M.D.

Abstract

As our society enters the information age, physicians are finding an ever growing role for computers in the practice of medicine. Computers are used for education, research, medical record keeping, communications and as a powerful reference resource. They have even served as electronic consultants to assist in diagnosis and medical decision making. Mississippians have been pioneers in the use of computers in research and education and have taken a very progressive view of the future of medical computing in our state. Resources such as the Mississippi Health Sciences Information Network have served to connect rural health practitioners to academic centers and other informational resources and improve the quality of patient care throughout the state. Internet users will find that there are many Mississippi medical institutions that have home pages on the world wide web that also connects us to the global medical community. Computers are rapidly becoming one of the most important new tools in the black bag of the modern physician.

Keywords: medical computing
internet
Mississippi physicians

Introduction

In Lewis Thomas' bestselling book "The Youngest Science" he describes the basic tools that his father used as a rural physician at the turn of the century[1]. The stethoscope, syringes and varied instruments were all used by the physicians of the time to gain insight and information about the medical condition of their patients. As the tools of medicine have become more sophisticated (echocardiograms, CT scans, etc.) the information acquired is much more complex and often difficult to interpret. Fortunately we are in the information age and the computer has become as integral and necessary a part of our life as was the stethoscope to Thomas' father. With its ability to store vast amounts of information and its absolute patience to analyze and make sense of mounds of tedious data, the computer has become our peripheral brain. But perhaps the most important function of the computer is that it is the great equalizer. It makes little difference if you are from the inner sanctions of our most prestigious universities or in a small private practice in the most remote parts of Mississippi. The computer allows us all equal access to the information we need to provide quality care for our patients. This article describes some of the different ways computers are being

used in our state and the impact they are having as the newest tool in our black bag.

Computer Reference Resources

In the past, graduating physicians who went out into private practice were generally separated from the academic world of medicine. They relied upon sporadic journal reading and annual meetings to keep them abreast of recent developments in their fields. Now, even in the smallest communities within our state, physicians are no longer isolated from the general medical community. There are a number of computer on-line services both locally and through the internet that allow the physician to search for the latest abstracts on any medical subject, obtain direct personal consultations with experts in a variety of fields or just catch up on their CME.

We are fortunate in our state that the Rowland Medical Library staff at the University of Mississippi Medical Center (UMC) has taken a visionary approach to their role as a resource. Beginning in 1989, the National Library of Medicine (NLM) has provided a series of grants to UMC for the development of the Mississippi Health Sciences Information Network (MisHIN). MisHIN connects rural health practitioners to academic medicine and other state health resources[2]. Through MisHIN, state physicians, nurses and students have access to Medline (NLM on-line database of the medical literature), various bulletin boards, MisHIN news, a calendar of professional meetings, continuing education activities and RoMeO. RoMeO is an acronym for Rowland Medical Online which specifically designates the UMC version of the Ameritech Horizon integrated library system for the on-line catalog containing the UMC library's books and journal holdings. It also allows access to a number of other biomedical libraries throughout the state as well as an electronic journal and several educational software resources.

The NLM and Medline can be accessed independently through the internet or through other on-line search services (Physicians' Online, Paperchase, etc.). The NLM also provides it own search-engine software called Grateful Med[3]. The full text of articles of interest found by way of Grateful Med can then be obtained through the Loansome Doc service of the NLM[3]. Individual searches with Grateful Med are relatively inexpensive but can become cumulatively costly if used often or if the searches are particularly difficult and comprehensive.

The Physicians' Online Information service provides medical information, software and communications services to its members at no cost[4]. Created by physicians for physicians, it is an interactive service used by thousands of physicians across the U.S. providing the most current medical information and analytic tools physicians need for timely clinical decision making. Members can choose from an array of on-line medical reference services and therapeutic decision support tools, including MEDLINE, AIDSLINE, AIDSDRUGS, AIDSTRIALS, Physicians GenRx, GenRx Drug Interactions, Clinical Alerts and QMR. Members also have access to communications services, topical professional forums, E-mail, software libraries, interactive CME programming and an internet pathway. In addition third parties (i.e. pharmaceutical companies) provide information, software and support for the service. This free service enables physicians to obtain the information they seek without training or instruction. The interface software is available in Windows and Macintosh versions and can be used on virtually any computer with a modem. (Call member services at 1-800-332-0009.)

For those with access to the internet there are a number of new medical information services such as Avicenna (http://www.avicenna.com) which provide free Medline searches using MESH terminology similar to Grateful Med. These services also connect users with academic institutions and consultant forums.

Computerized Medical Record.

As time constraints and the need for better documentation become imperative in the physicians daily practice, the role of computers in the development of an electronic medical record has become invaluable[5]. More than just sophisticated typewriters or word processors, computers have the ability to create relational databases in which the traditional history, review of systems, physical exam and differential diagnosis become well structured accounts of physician-patient encounters. With medicare and other health insurances requiring better documentation of services, the computerized medical record is a near necessity in the practice of modern medicine. Many medical institutions in the state such as UMC have realized this future direction and have made enormous commitments to the development of a general electronic medical record and computer services that will allow physicians easy access to vital information needed for the quality care of their patients. In the emergency department at UMC a new medical charting system is being instituted to help physicians take care of patients in a more timely and effective manner. It has been shown that patients generally welcome the use of computerized record keeping by their physician and that it gives them the sense that their doctor is on the cutting edge of medicine[6].

Computers in Medical Education

Computer simulations such as HUMAN (interactive computer model of human physiology) have been used since the 1970's at UMC to train medical students[7]. This was years before the first personal computers and a full decade before medical educational software became widely available. Since that time almost every department at UMC has some form of computer-assisted educational programs[8]. In the Department of Emergency Medicine we have a computer dedicated to resident educational materials which includes MD Challenger (for Board preparation), several ACLS interactive tutorials and general reference materials. The Rowland Medical Library also contains interactive, multimedia programs such as A.D.A.M. (Animated Dissection of Anatomy for Medicine) and Genesis (a cross-sectional anatomy identification tool) that can be accessed through RoMeO [9,10].

One of the tenets of modern medical education is to teach residents to practice evidence-based medicine[11,12]. Evidence-based medical practice is the treatment of patients based upon clear and present evidences from the current literature. This is as opposed to teaching based upon anecdotal experiences or simply "the way we have always done it". In the Department of Emergency Medicine at UMC we use a computer based within the department to teach residents to do immediate on-line searches for the latest diagnostic and treatment strategies from the current medical literature. These searches can be accomplished with relatively little time delays and at all hours of the day or night. The residents will then be able to carry this technique into their own practice no matter where they eventually settle. For this reason computer literacy has become a vital part of the medical education of today's physician [13].

Computers in Medical Research

While we do not usually think of Mississippi as a pioneer in the field of high technology, the use of computers in biomedical research has a long and illustrious history in our state[14]. Dr. A.C. Guyton's revolutionary use of computer models of the cardiovascular system to broaden our understanding of circulatory physiology and the mechanisms of hypertension has been recognized internationally as one of the great advances of modern medical research[15]. The Program Project Grant of UMC's Department of Physiology and Biophysics is centered around computer modeling of physiological systems and is one of the oldest continuing grants in NIH history. From Dr. Guyton's example a number of other computer oriented research projects have been developed at UMC. A number of aspects of medical computing including simulations studies, imaging analysis and medical decision analysis have been explored[16,17,18]. All of these efforts comprise a totally new and emerging field of medicine usually referred to as "Medical Informatics".

Clinical Computing

Clinical computing refers to the use of computers to assist in the care and management of patients. Computers are being used clinically in Mississippi in a variety of ways. They are sophisticated calculators that can compute the dosing and pharmacokinetics of drug regimens or analyze complex clinical data from cardiac catheterization or pulmonary function procedures[19]. They also store enormous amounts of information on disease and toxicological conditions in large databases that can be readily accessed in the clinics or emergency department.

The most exciting possibility is the application of computers in medical decision making[20,21]. However, the use of computers for this purpose has had as limited practical utility in our state as in most of the national medical community. It has been our experience in the trying to use clinical diagnostics programs such as QMR, Dxplain and Iliad within our emergency department that the differential diagnoses produced are either of such simplicity that they become useful only to the learning medical student, or they are so obscure as to become trivial. Such clinical decision support programs should be viewed as being a reflective tool along the same lines of the computerized readings of the EKG[22]. Then we can begin to see their usefulness as a guide to logical thinking and as a stimulus for ideas or diagnoses that may not have been otherwise entertained and not as an end in themselves. This function may find even greater utility in the future for the rural physician who is practicing without the ready assistance of a number of specialized experts.

Telemedicine refers to the use of computers and electronic communication networks to transmit diagnostic images and information acquired at one location for review and interpretation by a specialist with greater expertise at another location[23]. Rural physicians have used these resources to improve the quality of medical care in their communities. In our state some form of telemedicine has been practiced by individual radiologists who transmit x-ray and CT images. It has also been used for the expert interpretation of EKG and EEG tracings from a distance. However, it has not had a organized and centralized statewide development as has been accomplished in other states[24]. Such a development requires an enormous financial and time commitment and has not proven to be very effective in realizing its goals.

Mississippi Medicine on the Web

The internet is a worldwide collection of computers that communicate over a common networking system. It began in 1969 as a government sponsored effort to link diverse computer systems nationally for defense purposes. Many academic institutions and business also joined the internet internationally. In 1989 a group of physicists at the CERN in Geneva, Switzerland developed a method (http - hypertext transport protocol) by which internet users could access hypertext documents on remote computers for quality text and graphics images through interface browsers such as Mosaic. The ability of any one computer to link to any other remote computer on the internet led to the metaphor we call the "World Wide Web". Most specialties in medicine now have developed their own "internet-web communities" through which physicians can get updates on meeting, join discussion groups or obtain advise from fellow practitioners[25]. The internet also allows the transmission of electronic mail (e-mail) as a rapid means for informal communication from great distances.

There are a number Mississippi based "Home Pages" on the World Wide Web (WWW) that are medical related. UMC has a general introductory home page which has links to pages of some of the individual departments. These pages serve as an electronic brochure by listing faculty members, ongoing research, recent publications and educational resources. The Department of Physiology and Biophysics has a unique library of computer models of physiological systems with which a Web site visitor can run simulations of hemodynamic changes or explore the Hodgkin-Huxley model of nerve activation[26].

MisHIN also has an introductory WWW site with connections to RoMeO and other resources of the Rowland Medical Library. A listing of specialized medical consultants within the state is available through the MisHIN home page connection. A number of private hospitals and clinics such as Mississippi Baptist Medical Center and Methodist Medical Center in Hattiesburg also have individual Web sites. These sites provide details concerning the medical services available within the medical centers and also some financial and insurance information. A list of some of the WWW internet connections available

MISSISSIPPI MEDICAL HOME PAGES	INTERNET -WEB ADDRESSES
University of Mississippi Medical Center	http:// www.umsmed.edu/
School of Medicine - Registrar -Bulletin	http://sunset.backbone.olemiss.edu/dept/registrar/
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UMC - Psychology Program	http:// fiona.umsmed.edu/~sturges/brochure/programs.html
Mississippi Baptist Medical Center	http://www.health-futures.org/mbmc.html
Mississippi On-Line - Business (Medical)	http://msonline.nety/business/medical/
Gulfport Branch Clinic	http://www.nh_pens.med.navy.mil/pl_gport.htm
Healthplex	http://www.mc.edu/~uadwww/tour/
South Central Regional Medical Center - Laurel	http://www.njnet.com/~embbs/job/emcr6.html
Mississippi Sports Medicine & Orthopaedic Center	http://oscar.techlink.net/~msmoc/
Oxford-Baptist Memorial Hospital	http://www.ci.oxford.ms.us/group5/healthCare/bmhnm.html
MSU-The John C. Longest Student Health Center	http://www.msstate.edu/dept/health/
Hospitals - Medical Links	http://www2.netdoor.com/~billover/hospital.html
MSU-College of Veterinary Medicine	http://www.nmaa.org/aavmc/missippi.html
USM Department of Medical Technology	http://www.usm.edu/usmhburg/sci_tech/medtech/

Table 1. Listing addresses for Mississippi-based medical home pages on the internet.

within our state are provided in Table 1 with their calling addresses.

The Future

Lewis Thomas' father would never have predicted the computer derived imaging techniques of the CT and MRI scans at the turn of the century. Likewise, it is hard to predict the role that computers will have in the future of medicine. As the science of information processing becomes more sophisticated there will be new developments in medical technology that we can not begin to imagine. The expansion of the role of computers as peripheral brains and logical diagnosticians is also surely in our future. How we adapt to this new technology will decide how effectively we function as physicians. Some have feared that the computer may someday totally replace the physician. These naysayers have forgotten that medicine is still for the most part an art and there are human elements to patient care that simply can not be programmed. Rather we should embrace the computer and use it for the best care of our patients much as we do the stethoscope. (supported by HL51971)

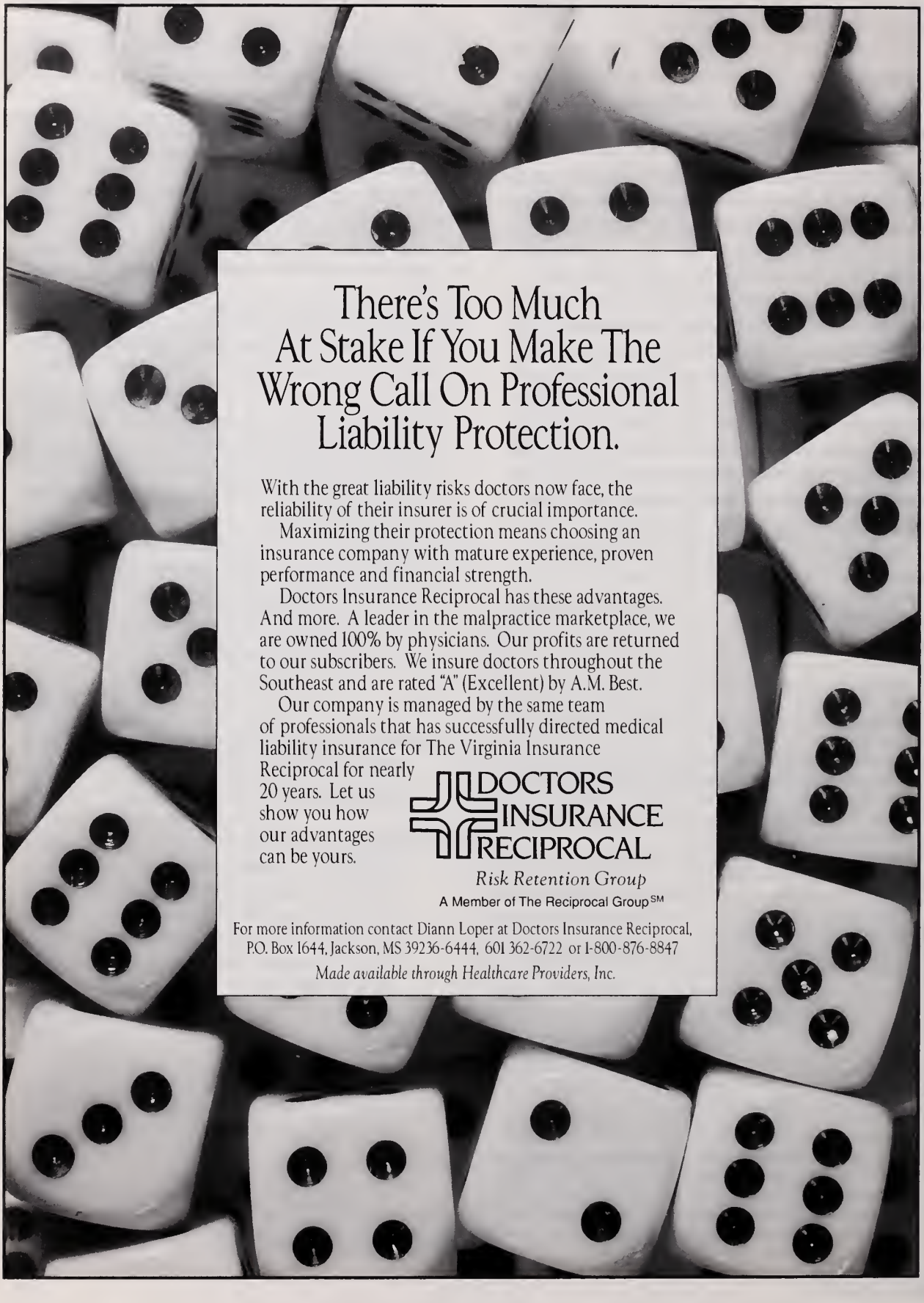
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Drownings in Mississippi 1992-1994: Frequencies and Distribution

Teresa Carithers, RD, MHS, LD
John C. Higginbotham, PhD, MPH

ABSTRACT

This investigation was conducted to determine the mortality rate due to drownings in Mississippi from 1992-1994. Drownings were defined as unintentional deaths from asphyxia while submerged or within 24 hours of submersion. Death certificate data including ICD-9 codes related to drownings, were received from the Mississippi State Department of Health. Variables assessed included age, age category, sex, race, death month, death day, place of drowning, and risk factors. Although drownings occurred in ages form 0-91 years, the highest mortality rates were found in the 14-17 year old age category (1 1.9 deaths per 100,000). Asian and Native American populations had the highest drowning mortality rates (23.6 and 22.6 per 100,000) when analyzed by race. However, this may be primarily due to lower populations. Males drowned five times more frequently than women. This is felt to be related to increased exposure. More drownings occurred on Saturdays and Sundays; and in the months of July, June; May, April, September, and August consecutively. Results presented here identify correlates of drowning fatalities which will enable strategic targeting of prevention programs and resources.

Key Words: Drownings, Submersions, Epidemiology, Prevention

Drowning, that is, an unintentional death from asphyxia while submerged or within 24 hours of submersion, does not discriminate with regard to age, race, sex or location. It has been estimated that over 75 people in Mississippi will lose their lives by drowning during this year. In addition, some 350 other individuals will have experienced a near drowning episode.

Drowning has been identified as a leading cause of death for infants and children less than two years of age in the United States. These deaths are typically classified into two major categories; "away from home" and "in-or-around-home". Public swimming pools and freshwater lakes or rivers are the major locations of "away from home" infant deaths, while residential swimming pools, bathtubs, canals and ditches are the more frequent sites of "in-or-around-home" infant drownings. Bucket-related drownings, another "in-or-around-home" site, have traditionally been more likely to occur in kitchens, bedrooms or on porches and include sleeping infants who roll off beds into liquid-filled containers."

Drowning also constitutes a significant health concern for adolescents. The adolescent and young adult age groups are the only groups whose overall death rates have increased nationally during the past twenty years.[4]

While the mortality associated with drownings can be devastating to those associated with the victim, the

morbidity and long-term medical course associated with submersion injuries is also phenomenal.[1,5,6] The cost factors associated with acute inpatient care for near-drowning survivors and the even higher costs for those who suffer severe brain damage and require skilled 24 hour, long-term care, constitute a substantial burden on health care resources. Therefore, prevention of drowning and near-drowning is clearly desirable.

Numerous studies support the approach that drowning prevention programs are preferable to treating victims of near drowning from a social, a medical and an economic standpoint. Ironically, however, in many instances, water safety and drowning prevention education is provided to families and communities only after a drowning or near-drowning.[1-7]

This investigation was conducted to examine the mortality rates due to drownings in Mississippi from 1992-1994 and to identify correlates of drowning episodes. The results should allow us to better characterize those groups at greatest risk along with environmental and seasonal influences, thus allowing effective targeting of future prevention programs and resources.

Methods

Prevalence data of drowning deaths in Mississippi from 1992-1994 was reviewed. A drowning is generally regarded as death from asphyxia while submerged or within 24 hours of submersion. The Public Health Statistics Division of the Mississippi State Department of Health (MSDH) provided information from all deaths due to drowning from 1992 through 1994. Data were retrieved from computerized death certificate records which included ICD-9 codes (E8309, E8319 - 20, E8322, E8329, E8384, E8389, E8839, E9102 - 04, E9108 - 09). Additional ICD-9 codes reflect drowning, however, these will not be addressed here due to the differing nature of the incident. For example, an individual might have been involved in a motor vehicle crash and as a result ended up submerged in a creek or river and drowned. These forms of drowning are not as amenable to intervention as the previously stated incidences. Therefore, only those deaths that were primarily associated with drowning were included in this study. Data extracted included sex, age, race, residence, place of drowning and date of death.

Age categories were established to provide a better foundation for comparison with other studies and national census reports. Categories included 0-4 years, 5-9 years, 10- 1 3 years, 14-17 years, 18-24 years, 25-34 years, 35-44 years, 45-59 years and 60+ years. These age distributions also allow for calculation of age specific mortality rates. These data were analyzed utilizing SPSS For Windows, Version 6. 1.[8]

Results

Between January 1, 1992 and December 31, 1994 there were 219 drownings in Mississippi. Of this number, 183 were males, 36 were females; 189 were Mississippi residents, 30 were visitors. Since the purpose of this investigation was to examine the overall problem of drownings which occur in Mississippi, analyses were not differentiated by residence. Figure I however presents the mortality rates for each county.

Age of drowning ranged from infancy (less than I year) to 91 years of age (mean=32.0, sd=22.28). Greater frequencies of drownings occurred at age 19 years (4. 1 %, n=9); 1 year (3.7%, n=8); 33 and 40 years (3.2%, n=7), respectively. A fuller delineation of age specific drowning mortality rates is presented in Table 1.

It is well known that ICD-9 codes, by design, provide limited detail on the causal factors contributing to drowning episodes.[9,10] Examination of the general categories does, however, provide some useful information and is frequently the only readily accessible form of information for such episodes, as is the case here.

Some 29.7% (n=65) of the reviewed cases involved drowning in swimming pools or quenching tanks (ICD code E9108). Drownings coded E8309, E8319, E8320, E8322, E8329, E8384 and E8389 were merged together for the purpose of our study as they all relate to some form of water transport injury or submersion precipitating drowning. Together they account for 25.5% (n=56) of the drownings. Both E9109 (non-specified accidental falling into water) and E9102 (recreational non-diving submersions) contribute 18.7% (n=41) of deaths. Bathtub drownings, E9104, accounted for another 3.7% (n=8); non-recreational or diving episodes (ICD code E9103), which can include drownings while trying to rescue others were 2.3% (n=5); and E8839, falling into a hole with water represented 1.4% (n=3).

Males drowned most often in water transport accidents (29%, n=53), swimming pools (28%, n= 52), recreational non-diving accidents (22%, n=40) and non-specified accidental falls into water (16%, n=29). Females primarily drowned in swimming pools (36%, n=13) or non-specified accidental falls into water (33%,n=12). Water transport drownings were more than twice as frequent for whites than blacks (n=34:n=14). However, percentages for recreational non-diving accidents, swimming pool deaths and non-specified accidental falling into water were very similar.

Only 163 out of the 219 death certificates specified the place of drowning. Site classification codes included

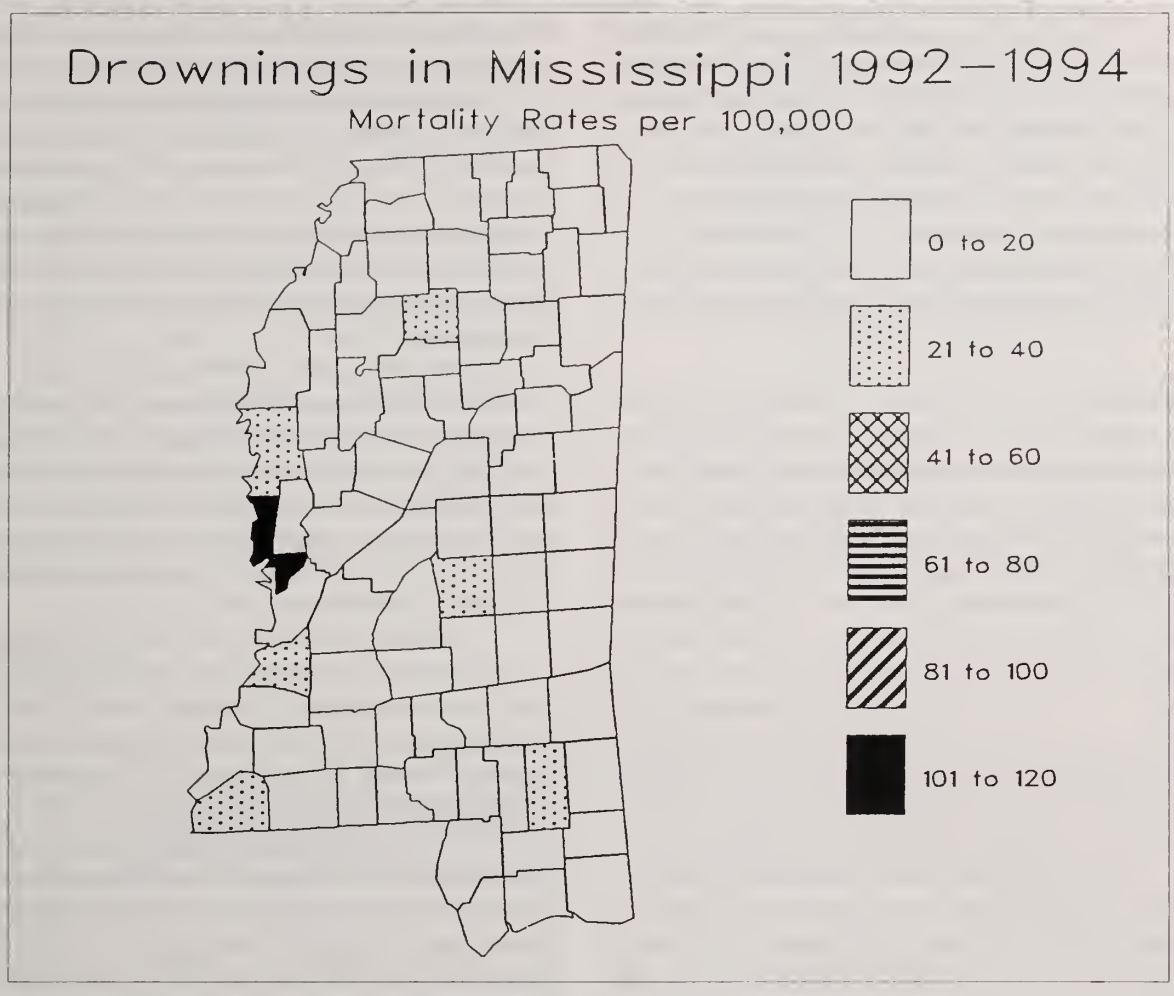


Figure 1

Age	Drownings	Mortality Rate
0-4	21	10.8
5-9	14	6.6
10-13	8	4.6
14-17	20	11.9
18-24	31	10.8
25-34	42	10.4
35-44	31	8.8
45-59	20	5.6
60+	32	7.5
Total	**219**	**8.5**

Table 1. Age Specific Mortality Rates (per 100,000)

home, farm, mine/quarry, industrial site, recreational site, street/highway, residential institutions, other specified places (which includes rivers, beaches, reservoirs, etc.), and other unspecified sites. Sixty-six drownings (40.5%) occurred in "other specified locations"; 40 (24.5%) at home; 30 (18.4%) at a recreational site; 10 (6. 1 %) on a street or highway; 8 (4.9%) on farms; 5 (3. 1 %) were coded as occurring in "other unspecified sites"; 2 (1.2%) at an industrial site; 1 (.6%) in a mine/quarry; and 1(.6%) at a residential institution.

Discussion

Although we recognize the limitations of death certificate data previously cited by others, to our knowledge it continues to be the most available source of mortality data for Mississippi.[11] ICD-9 codes were useful for identifying drowning deaths, but provided only minimal information related to predictors.[10,12] Data from emergency medical systems (EMS) has provided more descriptive and state-sensitive data in several previous studies, [11,14] however, the Mississippi Emergency Medical Division of the MSDH had, at the time of this analysis, not completed it's computerized registry. In the future, this registry will provide additional details for surveillance of a variety of mortality and morbidity data.

Given the aforementioned limitations of this investigation, it still provides several insights into the problem of drownings in Mississippi. Additionally, while much of the data is consistent with that found by other investigators in other states, there are some unique results that supplicate the need for further investigation and for special intervention. These areas are further delineated below.

Previous reviews of drowning in the United States have identified two distinct high risk groups: children under 5, and boys aged 15-19 years.[1,3,5,11,12] Mississippi data appears consistent with these findings with the highest death rates in the 14-17 year old age group - 1 1.9 deaths per 100,000. The 0-4 year olds, 18-24 year olds and the 25-34 year olds followed with 10.8, 10.8, and 10.4 deaths per 100,000 respectively.

Our results indicate that at least 40 drownings occurred at home. This figure includes all but 2 of the 18 drownings in the 0-4 year old group. These results concur with that proported by Brenner, et al who also held that prevention interventions targeted at the infant and toddler age groups should receive priority. [12] Our results confirm the need for continued parent and older child education regarding supervision, safety precautions and emergency response training.

Information from other states indicate that the male/female ratio for drowning deaths is 3: 1. [11] The data presented here for Mississippi places that ratio closer to 5: 1. These differences possibly relate to the increased exposure potential. For example, in Mississippi, more males are involved in water transport occupations than are females. An additional factor for this higher ratio may be gleaned from the numerous studies which indicate that males are more often involved in risk taking behaviors than are females, thus providing another means for exposure potential.

When death rates were examined by race, Asian and Native American populations had the highest death rates from drowning in Mississippi at 23.6 and 22.6 per 100,000. However, one must note with caution that these high mortality rates may be more indicative of lower population than an actual proportional increase in drowning risk. Blacks, Whites and Hispanics follow with 9.7, 7.2 and 6.8 deaths per 100,000 respectively.

Prevention strategies effectively implemented by other states include use of barriers with self-closing, self-latching doors and gates, pool safety covers, house door opening alarms, mandated pool fencing, pool covers, cardiopulmonary resuscitation (CPR) education, and alcohol/drug abuse prevention programs.[1,5-7,12,15] Mississippi data (especially identified high risk groups) correlate strongly with previous studies and thus utilization of these prevention strategies will benefit our state as well. Prevention education programs must continue to stimulate parental and public awareness to the fact that all individuals must be cautious when around any water source. Parent education programs must emphasize the increased risk of having a residential pool and the need for protective barriers. Parents must continue to be educated on the need for supervision of all infants and children including adolescents whether it be around residential or public water sources. Additionally, parents must be informed of the value of being able to perform immediate CPR once an event occurs. Specific concerns for Mississippi are addressed below.

Our data indicated higher frequencies of drowning in July, June, May, April, September and August consecutively, therefore prevention efforts should place the greatest impetus during this "drowning season". These efforts should emphasize prevention among minority individuals. High occurrence of water transport accidents dictate the need for quality assurance, training and ongoing education in safety precautions.

More deaths occurred on Saturday and Sunday than other days of the week and predominated in recreationally associated activities. Therefore, prevention programs for Mississippi should address recreational water safety to

include swimming pools, boats and natural water sources. This review also indicates the need for sites of water recreation such as beaches, pools and reservoirs to be closely monitored. One possibility would be to increase the number of safety personnel engaged for weekend surveillance.

The "buddy system" has traditionally been stressed with young children, adolescents and divers and as our results indicate should be stressed for the elderly when they fish, swim or walk in or around water sources.

While we acknowledge that knowledge is a necessary but not a sufficient component for behavior change, the information provided here does provide a set of focal points for others to further investigate and develop intervention programs to reduce these very preventable instances of near-drowning morbidity and drowning mortality.

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Reprints will not be available.

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Fred L. McMillan, M.D.

The President's Page

March Fricassee

I had difficulty narrowing this article to one subject area. Remembering a radio talk show I use to listen to on Friday afternoons while a resident at Tulane called Friday Fricassee, I decided to follow that disc jockey's format and delve a little into several areas.

Statue of Repose- At present, a malpractice law suit can be brought within two years of the act or within two years after the discovery that the incident might have caused an injury; therefore, if a patient discovers that a medical problem he/she is now having was possibly caused by a medical treatment or misdiagnosis twenty plus years earlier he/she can bring suit within two years of being made aware of this. The problem on both sides is witnesses being available and, particularly for the physician, is the difficulty of being able to properly give the jury the mindset of the standard of care at the time of the incident.

As I write this article, Tort Reform again appears to be a dead issue legislatively. The one piece of legislation we seemed to have a chance of passing this year, a Statue of Repose, was defeated when Senator Bennie Turner, from West Point, decided not to take it up before his Chaired Committee. This legislation would have limited to seven years the period between the act and the discovery of the incident. As it stands now there is no limitation as to the length of time that can exist between an alleged malpractice and the time that the patient discovers that the alleged malpractice may have caused him or her harm. For sure we will be back next year and I truly believe a little stronger legislatively in this regard.

Judicial Election Reform- I had the privilege to participate in a forum sponsored by the Mississippi Bar Association along with judges from Supreme, Appellate, Circuit, and Chancery Courts, other attorneys, journalists, business leaders, PACS, and legislators. The recommendation from the forum dealt only with elections not with the potential concept of appointment of judges. This forum resulted in about

nine recommendations:

1. That legislation be enacted placing a cap of $1,000 on contributions by an entity.

2. That legislation be enacted prohibiting unopposed judicial candidates from receiving campaign funds.

3. That legislation be enacted requiring excess Campaign funds to be paid to the Bar for funding of the process for enforcement of Canon 7 of the Code of Judicial Conduct. (Canon 7 requires a judge to refrain from political activity inappropriate to his judicial duty. More specifically, a judge or a candidate for election to judicial office should not act as a leader or hold any office in a political organization nor should he make speeches for a political organization or candidate or publicly endorse a candidate for office.)

4. That the Bar develop and implement a system for enforcement of Canon 7.

5. That the responsible officers should vigorously enforce the present laws regarding judicial elections.

6. That the Bar and other appropriate entities develop a system to monitor compliance by judicial election candidates with applicable canons and laws.

7. That the Bar, the Office of Secretary of State, and/or other appropriate entities produce a seminar on applicable laws and canons governing these elections with each judicial candidate and his or her financial chairman being required to attend.

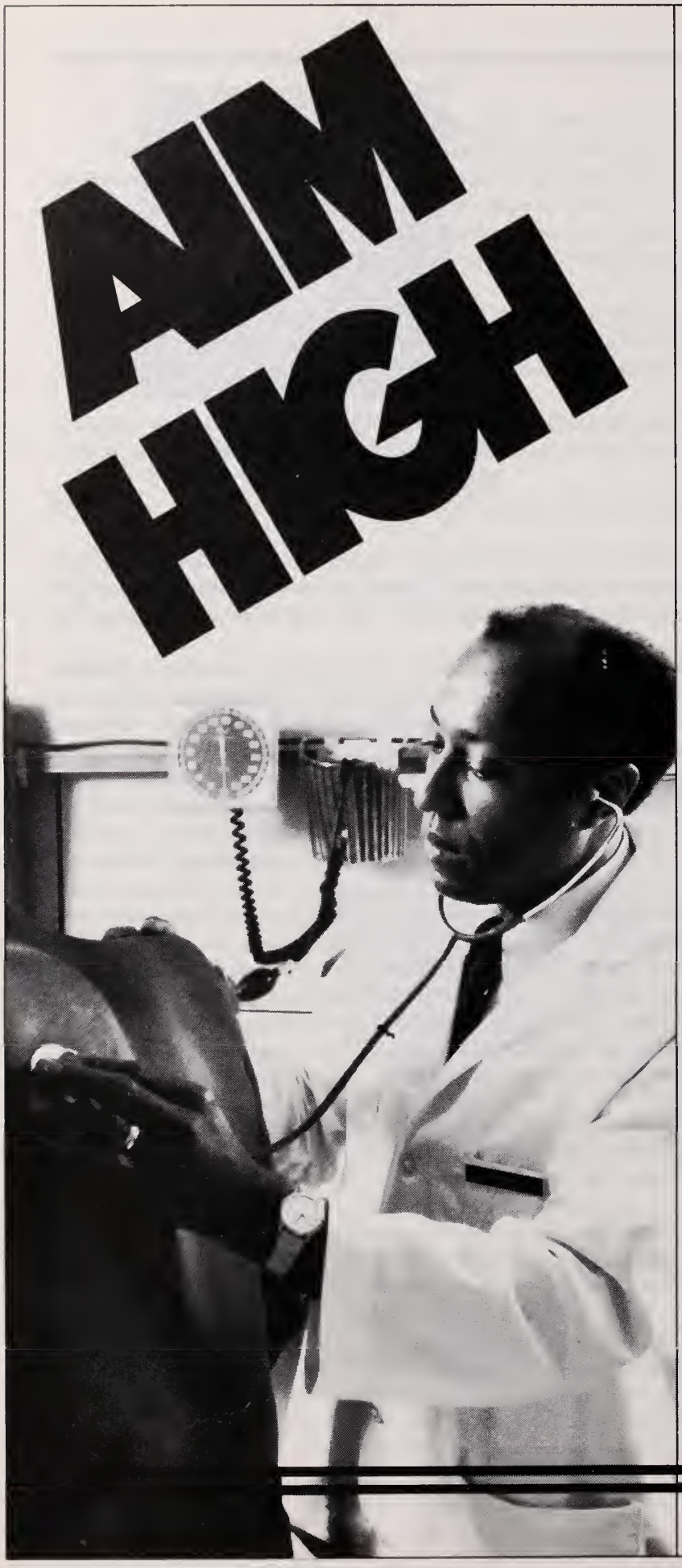
8. That all candidates be required to sign, upon oath, a pledge to comply with all applicable laws, canons, and regulations.

9. That the Mississippi Bar prepare and disseminate to the public, approximately one week before the election, information which will enable a comparison of relevant qualifications of candidates and include whether the candidate and his/her finance chairperson attended the pre-election meeting. Independently, the legislature is considering enacting legislation along the above same lines.

Practice Expense Relative Values- With the RBRVS, each medical review is assigned a value that is a blend of physician work 54%, practice cost 41%, and malpractice expense 5%. HCFA is proposing to change the practice cost component of the RBRVS with a research based approach. The AMA continues to express strong concern about the adequacy of the data and the methodology to be used in determining the new practice expense relative values, mainly because HCFA has not been able to gather enough accurate data (by its own admission) to adequately access what the true overhead costs are for all office based and surgical procedures. This new methodology for determining Medicare allowables for all the CPT codes is to go into effect on January 1, 1998. The AMA is strongly pushing for delayed implementation for at least one year, until the appropriate data has been obtained. We have had meetings with Senate Leaders, as well as Bruce Vladeck, the HCFA Administrator. The AMA is aggressively working with the national medical specialty groups to enact legislation to provide HCFA with a one year extension. It appears that the additional time will be granted that will allow HCFA and physician groups to work together to develop alternative relative values that bare some relationship to the physicians' actual practice expenses. The AMA's position is to delay implementation of this new approach so that the different specialty groups- Orthopaedics, Family Practice, Dermatology, etc. can have an opportunity to give appropriate input into the data HCFA uses in making their new determinations.

Well, that is the end of this fricassee. I will leave you with one other thought. The thought itself is not unusual, however, I think the presentation itself is. OPPORTUNITYISNOWHERE. Do you read this? ..... Opportunity is nowhere. Or, opportunity is now here?

Fred



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AIR FORCE

Editorial

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Managed Care Backlash

Across the country a great backlash is in progress against the managed care—HMO movement. Two key groups in the backlash have been people with chronic illnesses, because of the negative publicity they cause for the managed care industry, and doctors, both individually and organized, who have chosen to speak out. While managed care seems here to stay for a while (the medical inflation rate is down to 3% annually because of it) both the press and the politicians have become acutely aware of the disaffection of these two important groups.

Gag clauses were an early battleground. The fact of physicians prevented from providing full information and options to patients was too much for many politicians. Eighteen states now have laws prohibiting gag clauses. A more important issue, that of managed care organizations' prerogative to release physicians from contracts for economic reasons, has led nine states in the past two years to ban termination "without just cause."

In regard to access to care, 13 states now have laws requiring payment by health plans for emergency room visits on the basis of a "prudent layperson's" definition of emergency rather than the health plan's. And 28 states have enacted laws against "drive through deliveries," legislating a minimum 48 hour stay for the mother.

The legal front is active, too. Patients and their families have won huge awards over denial of care, most notably for denying bone marrow transplantation to treat breast cancer. The legal profession has focused on well publicized financial incentives for health plan executives and physicians for greater profit. For instance, some HMOs have been reported to keep thirty cents of each premium dollar. Chief executive officers of HMOs make considerably more than their counterparts in similar-sized corporations, about 60% more on average. U. S. Healthcare's CEO will reportedly receive $967 million in cash and stocks from the merger with Aetna.

Last year new federal guidelines forcing managed care organizations to disclose incentive payments to physicians were delayed after an outcry of protests from the organizations themselves. The particular trend in question was the popular one today of capitation-plus-bonus, the bonus usually representing 40 or 50% above the annual income if referrals for specialty care and hospital admissions are kept low. Well, perhaps this year.

It's hard to know where all of this will lead- probably to higher premiums as pressure forces the organizations to act on some of the worst abuses. Certainly, HMOs will not go away; some patients and employees can afford insurance only through this route. But curbs on gatekeeping and elimination of capitation-plus-bonus methods of payment would be positive steps. The big prize in the struggle would be controls capping profits and with access to medical care to be determined solely by clinical criteria.

A tough struggle? Sure. It would require a strong bond between doctors and patients. But, isn't the germ of that bond already there? And wouldn't the results be worth it?

-Leslie E. England, M.D.
Associate Editor

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"The Extinguisher," the AMA's Anti-Smoking Superhero, Visits Mississippi



"Look out camels, cowboys, and penguins. Your days of enticing kids to take up tobacco are coming to an end," said Randolph D. Smoak, Jr., M.D., member of the American Medical Association Board of Trustees. That certainly is the plan of the American Medical Association with its launch of a new cartoon superhero, "The Extinguisher," and his mentor and creator, "Doctor Nola Know," two new champions for America's kids in the fight against tobacco.

Standing about six feet, eight- with purple cape, his Spandex-bound muscles bulging to the delight of kids, "The Extinguisher" teamed up with "Dr. Know", played by Dr. Susan Buttross, associate professor of pediatrics at the University Medical Center. Their mission: to educate and protect children from the dangers of smoking. Together, they helped metro-area fourth and fifth graders wage their own "kid crusades" to "smoke out" and "extinguish" the cigarette industry's advertising and marketing campaigns targeted toward America's youth.

The super-duo visited six schools and the Capitol Street Boys' & Girls' Club in Jackson, Wednesday, February 19, as part of the AMA's nationwide public health campaign aimed at teaching elementary school-age children about the dangers of smoking and nicotine addiction. "The Extinguisher" and "Dr. Know" also made a stop at the State's Capitol to appear at a press conference organized by the Mississippi State Medical Association.

On the Capitol's front steps, MSMA President Dr. Fred McMillan introduced the superheroes, who commended Davis Magnet Elementary school-kids for their public service. The students cleaned up the grounds, eliminating the litter created by cigarette butts. Wearing surgical gloves, about seventy-five giggly children picked up enough cigarette butts to fill an entire trash bag. One-by one, each child exchanged their butt-filled baggy to "The Extinguisher" for a hand shake.

At the press conference, MSMA President Dr. Fred L. McMillan addressed the dangers of smoking and nicotine addiction and voiced MSMA's support of the Mississippi Juvenile Tobacco Access and Prevention Act of 1997. Mississippi Attorney General Mike Moore discussed this legislation which seeks to protect children from the dangers of smoking by prohibiting the sale or transfer of tobacco to persons under 18 years of age. Mississippi State Health Officer Ed Thompson spoke on the devastating effects of the tobacco industry's nicotine promotion to children.

A study published in the *Journal of the American Medical Association* showed that children as young as six years old were as familiar with "Old Joe Camel" as they were with Mickey Mouse, and that such familiarity is a known risk factor for smoking and tobacco addiction. To attest to this study, "The Extinguisher" conducted an experiment selecting ten student contestants at each of his appearances. He asked those not selected to remain quiet if they knew the answer and posed the question, "Can you name one cartoon character a cigarette company uses in their advertisements?" The contestants were asked to write their answer on their piece of paper. At the first school, Smith Elementary, seven out of ten of the fourth and fifth grade contestants answered "Camel." The ratio of students identifying "the Camel" was even higher at the other schools.

"The Extinguisher" then explained, "Before you were born, these companies only spent half as much on advertising as they do today and they are more likely today to spend their promotional money on things that appeal to young people. They'll put a cartoon character on your football field sideline, they'll put it on a t-shirt, cap, or sunglasses and give it to you. Why, they'll even paint it on the side of your favorite race car driver's automobile!" Then, he would asked a volunteer, "Why do you think a cigarette company would put a cartoon character in their ad?" The students inevitably replied, "because they want to get kids to smoke" or "because they know kids like cartoons." The experiment worked hands down each time.

So, now the AMA is giving the tobacco industry a run for its money with their new superhero. According to the cartoon narrative, "the Extinguisher" wasn't always a superhero. A short time ago, he was a young man on the brink of death. His diseased lungs had been so weakened by tobacco that desperate measures were needed to save him.

During the school presentations, "Dr. Know" opened by educating the children on why smoking is bad for you, before entertaining them with the story of saving the



The Extinguisher lunges from behind closed doors for a press conference on the State's Capitol steps.



Dr. Susan Buttross, associate professor of pediatrics at UMC, a.k.a. "Dr. Know", shakes students' hands.



Top: *The butt-kicking, superhero-duo, poses with students from Davis Magnet Elementary School.* Bottom: *Students participate in their "Can You Name A Cigarette Cartoon Character?" experiment at Casey Elementary School.*



young man, "I not only brought him back to life, but turned him into a scientific wonder with artificial lungs and super powers, including increased brain power and special heat-seeking devices able to detect cigarettes from miles away. I wanted to make sure "the Extinguisher" was able to kick butts wherever he finds them," Dr. Know said explaining her creation.

As Dr. McMillan said before introducing the butt-kicking, super-duo, "Smoking is not comic or cool." With its new cartoon characters the Extinguisher and Dr. Know as its secret weapons, the AMA and the MSMA will take on any one (or any animal) that threatens the health of our nation's kids.

At the end of a fast-paced, one day schedule of presentations, shuttling the two characters from one appearance to the next, assisting Josh Brewster with costume changes between each, it was obvious the enthusiasm expressed by both had touched thousands. As one little girl exclaimed, looking up at her teacher with a disturbed, serious look on her face, "Ms. Grace, I'm glad to see somebody's doing something about this." "I am too, Virgina." **-Karen Evers, Managing Editor**



At First Presbyterian Day School, "The Extinguisher" tells kids how they can be the real heroes.



MSMA President Dr. Fred McMillan introduced the superhero to eager students from Davis Magnet School.



The mighty "Extinguisher" descends the steps of the Capitol.



"The Extinguisher" gives his infamous high five.



Attorney General Mike Moore discussed the Mississippi Juvenile Tobacco Access and Prevention Act of 1997.



State Public Health Officer Dr. Ed Thompson spoke on the devastating effects of the tobacco industry's nicotine promotion to children.



The first presentation was made at Smith Elementary School.



Dr. Susan Buttross as "Dr. Know" at Poindexter Elementary School's after-school program.



"If each of you will tell just one person and ask them to tell another we can start to extinguish cigarette smoking."



Every day in the U.S., 3,000 young people begin to smoke - that's more than 1 million new smokers each year.



"The Extinguisher" at the Capitol Street Boys' & Girls' Club.



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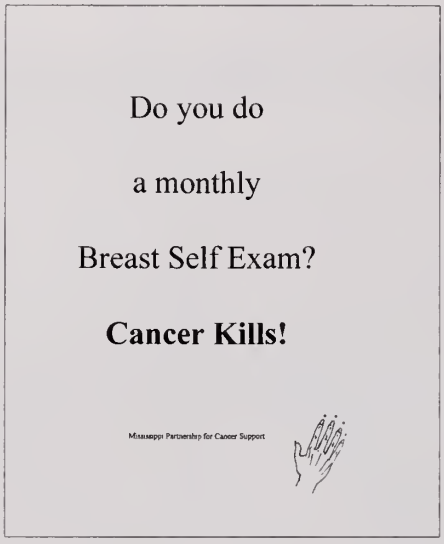
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Health Promotions Spotlight



• Breast Cancer is the 2nd leading cause of cancer death in women. Is your Mammogram due?

• 127 women will die today of Breast Cancer. Will you be alive tomorrow? Schedule your Mammogram today!

• One in eight women in their lifetime will develop Breast Cancer! Contact your physician today!

• Breast Cancer is the leading cause of cancer death in black women. Is your Mammogram due?

-Mississippi Partnership for Cancer Support

When Peggy Crawford began her term as Southern Medical Association Auxiliary (SMAA) Health Education councilor for Mississippi, she did not know that her sister would be diagnosed with breast cancer. Breast cancer awareness is emphasized nationally by SMAA. The work of the coalition formed by the MSMA Alliance with the MS Chapter of the AARP, and the MS Home Extension Service to combat the disease became even more meaningful to the Louisville native.

The group together accomplished many goals including:

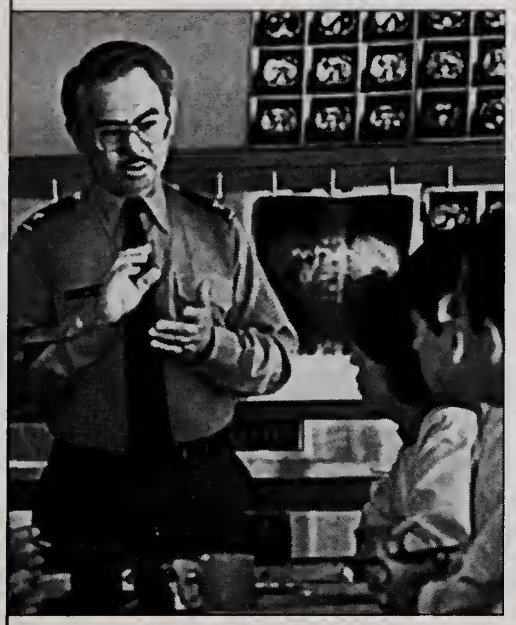
- Radio station announcements.
- 140 newspaper articles.
- Placed over 6,000 breast cancer awareness signs in public places, designed by Dr. Dewitt Crawford.
- Placed 1,200 Art of Detection Posters in the state, from the National Institute of Health.
- Provided four Breast Self Exam Models shared by eight colleges and universities.
- Promoted the use of pink awareness ribbons.
- Provided a program for "Senior Citizens Day" for over 800 participants.
- Provided over 80 programs on the project.
- Provided a booth at the Neshoba County Fair and pinned over 500 fair attendees with pink ribbons.
- And AARP is planning to provide 50,000 greeting cards to members this year reminding each to have a mammogram.

For their hard work and participation in the coalition for Breast Cancer Awareness, the MSMA Alliance was honored at the SMA Convention in Baltimore, Maryland. Not only did they sweep the state awards, but also took home the coveted Eileen Martin Award for the best health education project by a state or county alliance. This years convention marked the first time competition was held in the field of health education. Nancy Bush, of Laurel, President of MSMA Alliance, accepted the award. Peggy, you make us proud and congratulations on all your hard work.

Peggy's sister, Marsha Lawless, passed away on November 19, 1996.

-Mrs. Merrell Rodgers

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1st Annual Women's Healthcare Breakfast

The First Annual Women's Healthcare Breakfast was held at the Mississippi Capitol Building on January 22, 1997. The event was jointly sponsored by the Mississippi State Medical Association and the Mississippi Academy of Family Physicians.

During the Breakfast the women physician members in attendance had the opportunity to discuss legislative issues involving women's healthcare directly with many of our women legislators. Our Mississippi State Legislature has made great strides in women's healthcare, but there are many issues still to be addressed.

Dr. Lessa Phillips, Chair of the Department of Family Medicine at the University Medical Center (UMC), gave a "Big Picture" overview of the status of women's health care on a national and state level. Later Dr. Ralph Vance, Chair of Oncology at UMC, gave physicians and legislators an insightful look at "breast cancer," with an emphasis on the importance of screening mammography and early detection on long-term survival rates.

Physicians in attendance were: Mary Gayle Armstrong, Natalie Brookins-Reddix, Teri Dyess, Karen Flannagan, Laura Fowlkes, Judy Gearhart, Nina Moffitt, Ann Myers, Lessa Phillips, Sandra Pupa, Dwalia South, Nancy Tatum, Helen Turner and Rena Zimmerman.

Legislators in attendance were: Representative Norma Bourdeaux, Representative Alyce Clarke, Represenative Linda Coleman, Representative Mary Coleman, Senator Alice Harden, Representative Reta Holden, Representative Rita Martinson, Representative Patricia Miller, Representative Diane Peranich, Representative Eloise Scott, Representative Miriam Simmons, Representative Mary Ann Stevens, and Representative Frances Fredericks.

Others in attendance were : Patty Allred, Nicole Boyd, Karyn Inzinna, Evelyn Lighter-Cullins, Jennifer Myrick, Cherry Russell, and Lecia Scott.

The event was underwritten by Bristol-Myers-Squibb and Zeneca Laboratories.

Hopefully, this type of forum will open up candid and thoughtful discussion of women's healthcare issues. After breakfast, several of the physicians met at the MSMA building and discussed plans to form a women's caucus of MSMA.

-Dwalia South, Associate Editor



Left to right: *Doctors Nina Moffitt, Ann Myers, Helen Turner, Mary Gayle Armstrong, Nancy Tatum, and Karen Flannagan.*



Right to left: *Doctors Sandra Pupa, Teri Dyess, Dwalia South, Judy Gearhart, Laura Fowlkes, and Lee Ann Mordechai with the MS Academy of Family Phisicians.*

New Members

Alfarrawati, Mohammad N., Greenville. Born in Damascus, Syria, February 8, 1962; MD Damascus University School of Medicine, Damascus, Syria, 1986; internal medicine residency, same, 1986-87; clinical pathology residency, University of Boston Medical Hospital, Boston, MA, 1989-90; internal medicine residency, Bridgeport Hospital, Bridgeport, CT, 1990-93; pulmonary fellowship, University of Mississippi Medical Center, Jackson, MS, 1994-96; elected by Delta Medical Society.

Kelly, Richard Allen, Southaven. Born Aberdeen, MS, March 22, 1960; MD University of Mississippi School of Medicine, Jackson, MS, 1986; interned one year, Gadsden Hospital, Gadsden, AL; family practice residency, University of Mississippi School of Medicine, Jackson, MS 1987-89; elected by DeSoto County Medical Society.

Koskan, Allen J., Gulfport. Born Butte, NB, March 15, 1951; MD University of Nebraska Medical Center, Omaha, NB, 1977; interned in internal medicine, Eastern Virginia Medical School, Norfolk, VA, 7/77 - 12/77; ophthalmology residency, The State University of New York, NY, 1/78-1/79; ophthalmology residency, Louisiana State University School of Medicine, New Orleans, 1/79 - 6/80; glaucoma fellowship, Ochsner Foundation, New Orleans, LA, 7/80 - 6/81; glaucoma fellowship, Louisiana State University Medical Center, New Orleans, LA, 6/80 - 5/81; elected by Coast Counties Medical Society.

Poothullil, Thomas M., Biloxi. Born Cochin, Kerala, India, December 27, 1945; MD Kerala University Medical College, Kerala, India 1970; interned one year Fordham Hospital, Bronx, NY; internal medicine residency, Bergen Pines County Hospital, Paramus, NJ 1972-74; hematology-oncology residency, VA Hospital, New Orleans, LA 1974-75; pulmonary medicine fellowship, VA Hospital & Tulane Medical Center, New Orleans, LA, 1975-77; elected by Coast Counties Medical Society.

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Rayford, Edith F., Jackson. Born Crystal Springs, MS, June 8, 1958; MD Meharry Medical College, Nashville, TN, 1991; interned one year Albert Einstein Medical College, Bronx, NY; elected by Central Medical Society.

Roden, Karen B., Tupelo. Born Murray, KY, June 12, 1961; MD Vanderbilt University School of Medicine, Nashville, TN, 1987; internal medicine residency, Brook Army Medical Center, San Antonio, TX, 1987-90; hematology/medical oncology fellowship, same, 1990-93; elected by Northeast MS Medical Society.

Smith, William W., Ocean Springs. Born Ft. Eushs, VA, October 10, 1951; MD University of Mississippi School of Medicine 1985; psychiatry residency, University Medical Center, Jackson, MS; elected by Singing River Medical Society.

Yablon, Stuart A., Jackson. Born Washington, DC, July 8, 1961; MD University of Texas Medical Branch, Galveston, TX internal medicine residency Oral Roberts University School of Medicine, Tulsa, OK 1987-88; physical medicine & rehabilitation, University of Medicine & Dentistry of New Jersey, Newark, NJ 1988-91; fellowship in physical medicine, rehabili-



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tation and brain injury, Baylor College of Medicine, Houston, TX, 1991-93; elected by Central Medical Society.

DEATHS:

Alexander, R. L., Jr., Laurel. Born Laurel, MS, July 1, 1928; MD Tulane University School of Medicine, New Orleans, LA, 1953; interned one year, Charity Hospital, New Orleans, LA; died December 4, 1996, age 68.

Henry, John Kelly, Louisville. Born Braxton, MS, January 2, 1926; MD Washington University School of Medicine, St. Louis, Missouri, 1950; interned one year, Jefferson Hillman Hospital, Birmingham, LA; died January 22, 1997, age 71.

Imrie, Donald T., Madison. Born Rochester, NY, March 27, 1913; MD University of Rochester School of Medicine, Rochester, NY 1939; interned one year, Charity Hospital, New Orleans, LA; orthopedic residency, Tulane Service-Charity Hospital, New Orleans, LA, 1940-42; orthopaedic residency, Crippled Children's Hospital, Richmond, VA, 1942-43; died January 12, 1997, age 83.

McMullan, George K., Jr., Jackson. Born Washington, DC, June 20, 1942; MD University of Mississippi School of Medicine, Jackson, MS 1968; interned one year, Letterman Army Medical Center, San Francisco, CA; internal medicine residency, Brooke Army Hospital, Ft. Sam Houston, San Antonio, TX, 1969-73; cardiology fellowship, Harvard Medical Center, West Roxbury, VA, 1974-76; died January 19, 1997, age 54.


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Richard A. Pecunia, M.D., a plastic and reconstructive surgeon at Hattiesburg Clinic, successfully completed his requirements for certification by the American Board of Plastic Surgery, Incorporated. Pecunia received his medical degree from the Louisiana State University School of Medicine in New Orleans. He then completed a residency in general surgery at the Allegheny General Hospital in Pittsburgh, Penn., and a residency in plastic surgery at the University of Mississippi Medical Center.

Keith G. Goodfellow, M.D., recently completed requirements for certification as a Diplomate of the American Board of Obstetrics and Gynecology. Dr. Goodfellow has a private practice in Bay St. Louis. He is a graduate of Tulane University and earned a master of science degree in biological sciences from the University of New Orleans.

James Fite, M.D., a Grenada pediatrician, is among the new officers selected for the Mississippi Chapter of the American Academy of Pediatrics. Dr. Fite, who has a private practice and is on the medical staff at Grenada Lake Medical Center, is one of the chapter's new vice presidents. He is also a clinical assistant professor of pediatrics and a visiting professor at the University of Mississippi Medical Center. He has sat on numerous child health and welfare committees and organizations.

Orin F. Guidry, M.D., anesthesiologist, was elected assistant treasurer of the American Society of Anesthesiologists (ASA) at the conclusion of the society's annual meeting in New Orleans. Dr. Guidry is an anesthesiologist in private practice. He received his medical degree from Louisiana State University School of Medicine in New Orleans, where he also received residency training in general surgery. He completed his residency training in anesthesiology at the University of Mississippi School of Medicine. He has served ASA as a district director and past chair of the committees on governmental affairs (1989-91), legislative review (1995-96) and surgical anesthesia (1994-96). He is a member of the board of directors of the ASA Political Action Committee and the American Medical Association Section Council. He is also a diplomat and director of the American Board of Anesthesiology and a past president of the Mississippi Society of Anesthesiologists.

Charles Guess, M.D., a Jackson physician, held a one-man show of his oil paintings at Marie Hull Gallery in Jackson. Dr. Guess, a native of McComb, is a graduate of Mississippi State University and the University of Mississippi Medical Center. His talent for painting was fostered by instructors Connie Cain of McComb and Diane Norman of Jackson. His paintings reflect his travels as well as scenes closer to home and are set in an impressionistic style with emphasis on capturing the effects of atmosphere and light. Dr. Guess has participated in art shows and has won numerous awards in juried shows in the Jackson area. Most recently, he was awarded first place in oil painting at the American Physicians Art Association (APAA) Exhibit in Baltimore, Maryland. His paintings have hung in the Gulf South Gallery in McComb as well as in locations in Jackson, including Center Deli, the Governor's Mansion and a number of offices in the Sillers Building and the Carroll Gartin Building.

Arthur Eugene Wood Jr., M.D. of Inverness, MS, has completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians (AAFP), the national association of family doctors. AAFP members are required to complete a minimum of 150 hours of accredited continuing medical study every three years. The AAFP, which has more than 75,000 members, is one of the largest medical specialty organizations in the country. It was the first national medical group to require members to keep up with medical advancements through regular continuing medical education. Dr. Wood Jr has been an Active AAFP member since 1963. As a family physician, Dr. Wood Jr., is qualified to work in all major areas of health care and trained to treat patients of all ages for the vast majority of health problems.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

E. Greg Wood, III, M.D. of the Mississippi Spine Clinic in Jackson, was a guest lecturer to the North Dakota Academy of Family Physicians in Big Sky, Montana. Dr. Wood delivered two talks covering diagnoses and treatment of cervical and lumbar disc herniations.

William B. Geissler, M.D., Director of Sports Medicine at the University of Mississippi Medical Center, participated as faculty at the Arthroscopy Association of North America's course on "Wrist and Elbow Arthroscopy" in Chicago recently. Dr. Geissler also served as faculty for the American Academy of Orthopaedic Surgeons course on "Disorders of the Hand and Wrist" at the Orthopaedic Learning Center in Chicago.

Felix H. Savoie, M.D. recently served as visiting professor at Osaka Kosei - Nenkin Hospital and Osaka University Medical Center, Osaka, Japan. He also served as special lecturer for the 5th Annual Meeting of the Shoulder Arthroscopy Forum of Osaka, Japan. His lecture was on Advanced Arthroscopic Techniques of the Shoulder. Additionally, he recently served as lecturer at the 2nd Annual Society of South American Shoulder and Elbow Meeting in Santiago, Chile. His lecture was entitled "Reconstruction Arthroscopy of the Shoulder, Elbow & Wrist." He also served as lecturer at the Arthroscopic & Reconstructive Surgery 1997 meeting in Sun Valley, Idaho. His lecture topics included: "Arthroscopic Management of partial Rotator Cuff Tear," "Mitek Technique for Rotator Cuff Repair," "Arthroscopic Reconstruction for Multidirectional and Posterior Instability," and "Is Glenoid Replacement Necessary in Shoulder Reconstruction?"

William Brawner, M.D. was among 1,661 initiates from around the world who became Fellows of the American College of Surgeons during convocation ceremonies at the College's recent annual Clinical Congress in San Francisco. Dr. Brawner received a medical doctorate in 1989 from the University of Mississippi Medical Center and is currently practicing at Tupelo Eye Clinic. In 1994, Dr. Brawner received board certification from the American Board of Opthamology. Dr. Brawner has a strong professional interest in pediatric and adult eye surgery and disorders of the eye.

Elbert A. Duncan, M.D., published "Prostate Simulation" in *Medical Dosimetry.*

Jeanette Zuraws M.D., has been named delegate for Physical Medicine and Rehabilitation to the Medicare Canier Advisory Committee. She is now admitting patients to Pontotoc Hospital's Subcute Rehab Unit.

Frank Fortenberry, M.D., has received Board Certification by the American Board of Intemal Medicine.

James T. Trapp, M.D., received a Certificate of Added Qualifications in Vascular and Interventional Radiology by the American Board of Radiology.

John 0. Phillips, M.D., Ph.D., presented a lecture entitled "Immunobiology of Biliary Epithelium at a Post Graduate Course for the American Association for Study of Liver Disease in Chicago.

Gerry Ann Houston, M.D., Eric McVey, M.D. and **Al Johnson, M.D.** of the Mississippi Baptist Medical Center announce plans to hold the fourth annual oncology conference April 3-6, 1997 at the Fiesta Americana Coral Beach resort in Cancun, Mexico. This multispecialty conference is designed to include a broad discussion of oncology-related topics. For information about the conference, call Carla Moss, Oncology Projects Coordinator, at (601) 973-1561.

Michael E. Jabaley, MD, FACS was the opening presenter in February for the 13th annual Plastic Surgery Educational Foundation Teleplast series. Dr. Jabaley demonstrated and commented on the principles and current practice of internal fixation of hand fractures and osteotomies. Through the auspices of the American Society of Plastic and Reconstructive Surgeons, Teleplast provides an interactive setting in which actual videotaped operations and post-operative patient examinations are presented along with a live call-in segment to a panel of experts. Teleplast is broadcast four times each year to more than ninety hospitals and medical centers throughout the United States, Canada and Mexico. Dr. Jabaley is Professor (Clinical) of Plastic and Orthopaedic Surgery at the University of Mississippi School of Medicine and has been in private practice for plastic and reconstructive surgery for over twenty years. Dr. Jabaley currently serves as President of the American Association of Plastic Surgeons.

Here's Our Agenda

It's simple. It's straightforward. And it represents the future of medicine. The American Medical Association presented to the Republican and Democratic leadership this agenda for the upcoming 105th Congress. Your AMA membership strengthens our voice in support of physicians and their patients. . . and will enhance our efforts to turn these goals into reality.

- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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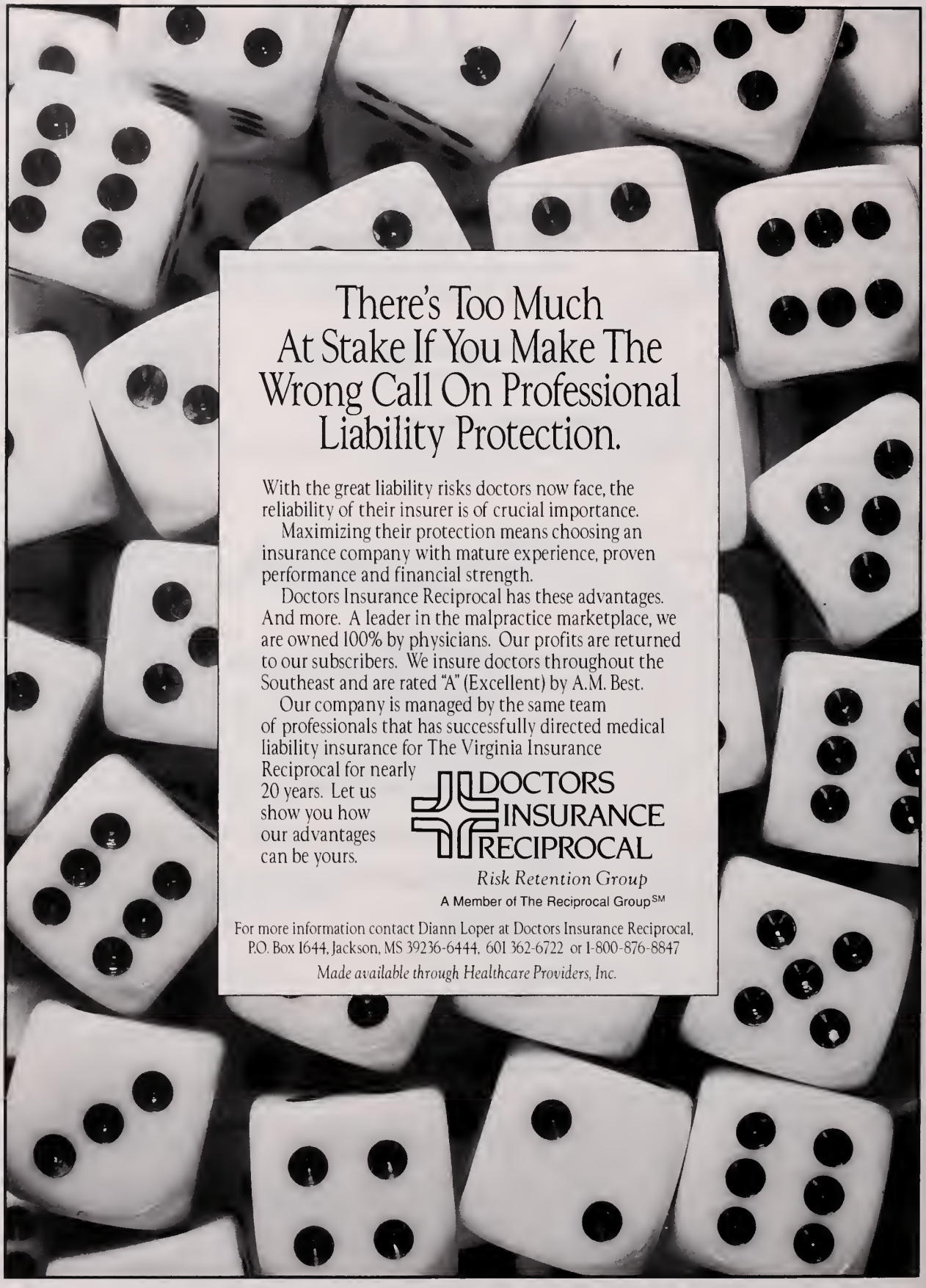
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What's New in the Prevention, Diagnosis and Treatment of Venous Thromboembolic Disease

James S. Jones, MD, FCCP

Introduction

This is the first of a series of presentations made by Mississippi physicians at the annual St. Dominic's Winter CME Meeting which took place in February 1997 in Park City, Utah.

SUMMARY

Incidence

Venous thromboembolism is a major cause of death and morbidity among hospitalized patients. In this setting, it has been estimated that pulmonary embolism causes death in more than 1 00,000 patients each year in the United States and contributes to the death of another 100,000.[1] These figures were first quoted by Dalen and Alpert 20 years ago and have been substantiated in a recent community-wide study conducted in 16 short-stay hospitals in metropolitan Woster, Massachusetts, where the annual incidence of verified pulmonary embolism was 23 per 100,000 central Massachusetts residents with an in-hospital case fatality rate of 12%.[2] Extrapolation of this data suggests that approximately 260,000 cases of clinically recognized venous thromboembolism occur each year in patients hospitalized in acute care hospitals in the United States. The disease, however, is often clinically silent with pulmonary embolism being unsuspected in 70-80% of the patients whose conditions are diagnosed at autopsy. The actual incidence of venous thromboembolism may be greater than quoted. This is thought to be because of the low rate of autopsy in the United States and the failure in the Woster study to include non-acute care facilities, such as rehabilitation hospitals and nursing homes, where the incidence of pulmonary embolism may be higher. These considerations lead to the conclusion that fatal pulmonary embolism may be the most common preventable cause of hospital death. Indeed, it has been estimated that 10-15% of all in-hospital fatalities in the United States are the result of pulmonary embolism.[3]

Risk Factors

Much is known about risk factors for venous thromboembolism. Studies have confirmed risk factors to include immobilization, trauma, and surgery with or without immobilization. In a large prospective study of patients with venographically-proven proximal venous thrombosis, patients with one or more of these risk factors for DVT constitute 54.7% of the patients.

Additional risk factors include age greater than 60, male gender, cancer, heart failure, S1:E, and lower limb arteriopathy. A recent review of 16,000 Medicare claims indicated that a diagnosis of venous thromboembolism supported the evidence that VTE is a common problem in the elderly and that the rates increase steadily with increasing age. Much study has pointed out that major trauma constitutes a major risk factor for venous thromboembolism. In a recent study, DVT was diagnosed in 201 of 349 patients (58%) with major trauma. 18% of the cases were proximal DVT. Breakdown of the DVT rates by site of injury are as follows: lower extremity 62.2%; spine 62.1 %; head 53.8%; face, chest and abdomen 50.4%.

Cancer is a well-documented risk factor associated, with VTE. A recent retrospective study of 4,399 patients who underwent venography for suspected DVT between 1984 and 1988 divided patients into those with positive venography an those with negative 1997 venography. Cancer subsequently developed in 150 of 1383 (10.8%) patients with positive venography as opposed to 182 of 2412 patients (7.5%) without thrombosis. Malignancy developed in 66 of 15O patients (44%) with thromboses compared to 37 of 182 patients (20%) without thromboses. Those cancers were detected by history, physical exam and simple lab tests (extensive screening was not required).

Studies continue to support the association of VTE with primary or secondary brain tumors. Documented VTE developed in 18 of 64 patients (28%) with high grade gliomas.[4,5,6,7,8]

Hypercoaguable State

For a number of years, the most talked about states of hypercoagulability had to do with those associated with malignancy and those associated with young women who took oral contraceptives and smoked. Recently, the attention of the literature has tuned toward three hematologic abnormalities predisposing to venous thrombosis:

1. Antithrombin III deficiency
2. Protein S deficiency
3. Protein C deficiency

The real excitement of late deals with activated protein C resistance. Numerous retrospective controlled studies have identified the presence of activated protein C resistance as the most common abnormality predisposing to venous thrombosis. Using the plasma assay, APC resistance has been demonstrated in approximately 21 % of unselected patients with venous thrombosis and between 33 and 62% of patients with a family history of venous thrombosis. Surprisingly, 5-7% of the asymptomatic population has been found to have APC resistance. APC resistance is caused by point mutation in the gene that codes for factor V. The mutant factor V does not bind properly to protein C and is, therefore, resistant to deactivation. [9, 10]

DVT Prophylaxis

In October 1995, a summary of the Fourth ACCP Consensus Conference on AntiThrombotic Therapy was released in *Chest* (*Chest*. volume 108, number 4, October 1995, supplement). These are attached in Appendix A and are self-explanatory. Despite overwhelming evidence of the efficacy of a wide variety of prophylactic agents, surveys conducted in the United States, England, Sweden, Switzerland, Spain and Australia document wide practice variations among physicians with 28-100% of respondents indicating that they routinely use prophylaxis. A 1986 study of more than 2000 patients with multiple risk factors hospitalized at 16 acute care hospitals showed that only 1/3 of those patients received prophylaxis.

Heparin Therapy For Pulmonary Thromboembolic Disease

The greatest advances in treatment in the last 2 years have involved refinements in the effectiveness and safety. Using a weight-based nomogram, 97% of patients exceeded the therapeutic threshold within 24 hours compared to 77% in the standard care group. Bleeding was not a problem. It is apparent that in 1996, Heparin dosing should be individualized to the weight of the patient. [11]

Heparin Induced Thrombocytopenia

Thromboocytopenia is a well-recognized complication of Heparin therapy. Two forms exist: an early benign reversible non-immune thrombocytopenia, and a late, more serious, IgG mediated immune thrombocytopenia.

The immune form of Heparin-induced thrombocytopenia (HIT is characterized by strong IgG mediated platelet activation and is associated with a substantial risk of thrombotic complications. The incidence is uncertain because prospective studies have not generally tested for pathogenic HIT-1gG. However, a recent clinical trial that compared unfractionated Heparin with low molecular weight Heparin suggested that the incidence of HIT was approximately 1% at 7 days, 3% at 14 days in patients receiving unfractionated Heparin and 0% in those patients receiving low molecular weight Heparin (Lovenox). HIT usually begins between days 5 and 15 of Heparin therapy.

A rapid thrombocytopenia usually occurs in patients who have received Heparin within 3 months, an observation that suggests that preexisting IgG rather than an amnestic response is responsible for rapid platelet fall. HIT associated thrombosis can be heralded by a fall in platelet count without overt thrombocytopenia, e.g. a falling platelet count from 350,000 to 150,000. For this reason, patients who receive Heparin should have platelet counts daily. HIT is a highly prothrombotic disorder although many case series have emphasized the association of HIT with arterial thrombosis ("white clot syndrome"). Studies have also shown the incidence of venous thrombosis (particularly proximal deep vein thrombosis in pulmonary embolism) strongly associated with HIT.

Venous thromboembolic events outnumbered arterial events by a ratio of 4:1 in a large 14 year retrospective study of serologically confirmed HIT in one medical community. Prospective study suggests that HIT associated thrombosis occurs in approximately 1% of patients who receive unfractionated Heparin for more than 5 days.[12]

Low Molecular Weight Heparin

Low molecular weight Heparin is clearly the coming treatment for pulmonary thromboembolic disease. More articles are published yearly about its efficacy as a primary treatment modality for both venous thrombosis and pulmonary thromboembolic disease. Its attractiveness lies in its ease in administration (once or twice daily subacute administration) and its lack of required lab and associated dosage adjustment.

At this time, however, it is not indicated for primary treatment of either deep vein thrombosis or pulmonary thromboembolic disease. Its sole indication is for DVT prophylaxis in patients undergoing hip surgery. Numerous articles attest to its effectiveness in prevention of deep vein thrombosis in multiple surgical settings. Likewise, it appears to have significantly less potential for inducing IgG related thrombocytopenia. (However, it is still contraindicated in patients who have HIT.) At present, a large prospective clinical trial comparing low molecular weight Heparin and unfractionated Heparin in the treatment of pulmonary thromboembolic disease is needed.

Appendix A

Prevention of Venous Thromboembolism

Following are recommendations for the prevention of venous thromboembolism.

1. In low-risk patients undergoing general surgery involving minor operations who are younger than 40 years and have no clinical risk factors, no specific prophylaxis other than early ambulation is recommended.

2. It is recommended that elastic stockings, low-dose heparin (LDH) (given every 12 hours), or intermittent pneumatic compression (IPC) be used in moderate-risk patients undergoing general surgery who are older than 40 years and are undergoing major operations but who have no additional clinical risk factors for venous thromboembolism.

3. It is recommended that LDH (given every 8 hours) or LMW heparin be used in higher-risk patients undergoing general surgery who are older than 40 years, who are undergoing major operations, and who have additional risk factors.

4. In higher-risk patients undergoing general surgery (as profiled in recommendation 3) who are prone to wound complications, such as hematomas and infection, dextran or IPC would be a good alternative choice for prophylaxis.

5. In very high risk patients undergoing general surgery who have multiple risk factors, it is recommended that effective pharmacologic methods (LDH, LMW, heparin, or dextran) be combined with IPC.

6. In selected high-risk patients undergoing general surgery perioperative warfarin therapy may be used.

7. It is recommended that aspirin not be used for prophylaxis patients undergoing general surgery.

8. In patients undergoing total hip replacement, warfarin, LMW heparin, and heparin in adjusted doses are the most effective prophylactic agents and are highly recommended for routine use. Although other agents, such as LDH with or without dihydroergotamine, dextran, aspirin, IPC, and elastic stockings, reduce the overall incidence of venous thromboembolism, they are less effective and should not be used routinely.

9. It is recommended that warfarin or LMW heparin be used in patients with hip fractures. Dextran, LDH with or without dihydroergotamine, and aspirin are less effective and cannot be recommended for routine use.

10. It is recommended that IPC be used in patients undergoing knee surgery.

11. Placement of a prophylactic inferior vena cava filter may be considered in selected high-risk orthopedic and multiple trauma patients in whom other forms of prophylaxis would be contraindicated or ineffective.

12. It is recommended that IPC with or without elastic stockings be used in patients undergoing intracranial neurosurgery.

13. In patients with acute spinal cord injury with paralysis, adjusted-dose heparin or LMW heparin is recommended for prophylaxis. Warfarin or IPC prophylaxis may also be effective.

14. In multiple trauma patients, it is recommended that IPC, warfarin, or LMW heparin be used when feasible.

15. It is recommended that LDH be used in patients with myocardial infarction. Full dose anticoagulation is also effective.

16. In patients with ischemic stroke and lower-extremity paralysis, LDH, and LMW heparin are effective. Warfarin, IPC, and elastic stockings are probably effective as well.

17. It is recommended that warfarin (1mg/d) be used in patients with long-term indwelling central venous catheters to prevent axillary-subclavian venous thrombosis.

Appendix B

Antithrombotic Therapy for Venous Thromboembolism.

Following are recommendations for the treatment of thromboembolism.

1. Patients with deep vein thrombosis or pulmonary embolism should be treated with intravenous heparin or adjusted-dose subcutaneous heparin sufficient to prolong the aPTT to between 1.5 and 2.5 times the control value.

2. It is recommended that treatment with heparin be continued for 5 to 10 days and that oral anticoagulation therapy be overlapped with heparin therapy for 3 to 5 days. For many patients, heparin and warfarin therapies can be started together and heparin therapy discontinued on day 5 or 6 if the PT (INR) is in the therapeutic range. For massive pulmonary embolism or iliofemoral thrombosis, a longer period of heparin therapy may be considered.

3. Long-term anticoagulant therapy should be continued for at least 3 months with the use of oral anticoagulant agents to prolong the PT to an INR of 2.0 to 3.0, or adjusted-dose heparin to prolong the aPTT beyond 1.5 times the control value for most of the dosing interval, when oral anticoagulant agents are either contraindicated or inconvenient.

4. It is recommended that patients with recurrent venous thrombosis or a continuing risk factor, such as AT III deficiency, should be treated indefinitely.

5. Symptomatic isolated calf vein thrombosis should be treated with anticoagulation for 3 months. If, for any reason, anticoagulation therapy cannot be given, serial non-invasive studies of the lower extremity should be performed to assess proximal extension of thrombosis.

6. The use of thrombolytic agents in the treatment of venous thromboembolism continues to be highly individualized. Further clinical investigation is needed before more definitive recommendations can be made.

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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XVI

Selection and Preparation:
Edward F. Daly, II, M.D.
Nancy T. Kubiak, M.D.

Joe C. Files, M.D., *Editor*

Differential Diagnosis: James L. Achord, M.D.
Pathological Findings: Cynthia Lynch, M.D.

CASE PRESENTATION

The patient is a 63 year old white gentleman with a 9 month history of more than 10 small white stools a day, described as "like gravy." They occur at night on occasion, often 4-5 hours postprandially. He denies symptoms prior to nine months ago. There is no history of melena, hematochezia or abdominal pain. Despite an increased appetite, he has lost 60 pounds over the last nine months. Two weeks prior to admission, he noticed the development of lower extremity edema. He denied any symptoms of heart failure, contact with ill persons, food intolerance, or ingestion of raw meat or shellfish. He is originally from Ohio but has not traveled outside the Southeastern United States in the past five years. Investigation of his illness in another hospital three months prior to admission included a gastrointestinal x-ray series but he is unaware of the results. Stools sent to our facility six weeks prior to admission were negative for Sudan stain, ova and parasites, and routine enteric pathogens. A flexible sigmoidoscopy done as an outpatient was grossly normal but revealed nonspecific colitis on histologic examination. The patient was started on sulfasalazine without symptomatic improvement. Numerous antidiarrheals also failed to improve his diarrhea.

His past medical history includes a left clavicular fracture. He has had a left inguinal hernia repair. His medications include sulfasalazine, 500 mg. t.i.d. and over the counter antidiarrheal medications. He is not allergic to any medicines and does not smoke or drink alcohol.

On physical examination he had a blood pressure of 110/60, a pulse of 52 beats/min, respirations of 16/minute and a temperature of 94.2 F. He was a well developed, thin white male in on distress. No adenopathy was noted. No heart murmers, rubs, gallop rhythm or extra sounds were heard. His lungs were clear to auscultation and his abdomen was scaphoid with normal bowel sounds. He had no hepatosplenomegaly or abdominal masses. On rectal examination, there were no palpable lesions. The stool was brown and the fecal occult blood test was negative. There was no cyanosis or clubbing but there was 2 plus edema of the lower legs bilaterally. On laboratory examinations, the hemoglobin was 12 gm/dL, platelets 188,000/dL, the mean corpuscular volume was 188, and the RDW was 18. The white cell count was 3,200 cells/dL. The differential white cell count showed 41% segs, 52% lymphs, 4% monos and 1% eosinophils with 14 nucleated red blood cells. The serum iron was 63 mcg/dL. Serum B12 and folate levels were not obtained. Prothrombin time was 15 seconds; the partial thromboplasin time was 28 seconds. The sodium was 139 mmols/L, potassium 4.4 mmols/L, chloride 107 mmols/L, CO2 29, and the BUN and creatinine were normal. The glucose was 92 mg/dL. Alkaline phosphatase was 145 IU and the AST was 31 IU. Total protein was 5 mg/dL with an albumin of 2.5 mg/dL, the total bilirubin 0.7 mg/dL, calcium 7.8 mg/dL, magnesium 1.8 mg/dL, and phosphorus 2.9 mg/dL. The urinalysis was normal with normal electrolytes, specific gravity of 1.007 and pH of 6. A 72 hour stool collection was not collected when his diarrhea in the hospital decreased on admission. His xylose absorption test showed a plasma level at 0 hours of 0, at 2 hours was 1.3 mg/dL and at 5 hours was 3.3 mg/dL. The urine xylose at 5 hours was 3.3 mg total excretion.

For Dr. Achord, our objective is to please discuss the differential diagnosis in this patient, the preferred method of establishing the diagnosis and possible findings.

Dr. James Achord: From a gastroenterologic standpoint, this is a fairly straightforward case. We will see whether or not it is straightforward enough for me to draw proper conclusions. There are several omissions that I would like to know about and perhaps we will learn more about those as the case unfolds.

In summary, we have a 63 year old man who says he was previously healthy, has what sounds like

steatorrhea, and who has lost a great deal of weight in 9 months despite a good appetite and edema. I would point out that when a patient says they are healthy, they mean that they are in their usual state of health, not that they were healthy and without disease. His diarrhea is his major complaint and his description is adequate to draw some tentative conclusions. What is not reported is the odor or the presence or absence of observed grease. It really is true that our own stool, while not pleasant to us, is not offensive. In the case of patients who have steatorrhea, the odor is not only offensive to those around them, but is offensive to themselves. This is important information to have. There are several important negative findings that are pointed out in the protocol. He did not complain of abdominal pain, had had no melena or hematochezia and had not been out of the country in over five years. This does not rule out certain diseases such as Crohn's or tropical sprue but it makes them unlikely. It is important to document weight loss because patients are often quite inaccurate in estimations of their own weights. Some tests were obtained simply because he had diarrhea. I refer specifically to stool for ova and parasites. This test is a zinc flotation method in most clinical laboratories and destroys the trophozoites of parasites, a necessary finding in most cases of parasite-induced diarrhea. A study done by a GI Fellow in another institution a few years ago (but published only in abstract form) looked at several hundred such tests ordered for a workup of diarrhea; only one was positive. If one wants to know if parasites are present in a patient with diarrhea, examination of fresh stool should be ordered. In fact, the majority of parasites in the USA do not cause diarrhea with the important exception of giardia and, rarely now, amebiasis.

It is obvious from the outset that with multiple mushy stools, weight loss despite a good food intake and and otherwise unexplained peripheral edema, malabsorption should be considered a high probability diagnosis. In this regard, the Sudan stain for fecal fat done before admission carries little weight. I realize that textbooks commonly list this test as useful. Unfortunately, as it is usually done, it is insensitive even though it is specific. In my experience, one must have at least 15 gms/day of fat excretion before it becomes consistently positive, leaving room for many diagnostic errors. Because it is specific, a positive Sudan stain on stool is reliable but a negative one is not. The stool was also examined for pathogens that would explain certain cases of diarrhea but not malabsorption. Giardia found in fresh stool examination is associated with malabsorption if the infestation is very heavy. Most of the time, malabsorption is not present. The patient was started on sulfasalazine presumably because the biopsy was said to show nonspecific colitis but clearly this histologic finding does not explain this man's clinical story and I am sure that no one expected the treatment to cure him. He was given antidiarrhea medication, a reasonable symptomatic treatment. Interestingly, the fecal occult blood test was reported to be negative. In patients with malabsorption, it is very common to have positive tests for fecal occult blood because malabsorption of red meat causes positive tests as do other nutrients that would otherwise be digested and absorbed. This is also true, incidentally, in patients who have had a Bilroth II reconstruction.

Further examination of his laboratory results shows a significant hypoalbuminemia and his total globulins were low normal at 2.5 gm/dL. These values suggest an element of protein losing enteropathy that is common in malabsortion of mucosal origin. He has macrocytic anemia but we do not know what his serum B12 or folate levels are. Patients with malabsorption also malabsorb vitamin B12 and folate with resulting macrocytic anemia. Since we do not have a bone marrow aspiration, we cannot say that his anemia is macrocytic. His white blood cell count is a bit low and this also suggests severe B12 and/or folate deficiency. He has multiple nucleated red blood cells which means that he has a very active bone marrow with rapid turnover of cells. I do not believe this reflects underlying hemoatologic disease in this case. Patients with steatorrhea, which we are assuming he has, malabsorb the fat soluble vitamins, primarily A, D, K and E. It is notable, therefore, that his prothrombin time is slightly prolonged and suggests a deficiency of vitamin K. Vitamin A causes night blindness which is not mentioned. He did have a fractured clavicle which as not associated with trauma. Again, we have no information on how or why this fracture occured. His slightly but definitely elevated alkaline phosphase, in the absence of evidence of liver disease, suggests bone disease as occurs with vitamin D deficiency. We are not told if he has bone pain. Most patients who have osteomalacia/porosis due to malabsorption do not, in fact, have bone pain. A serum calcium of 7.8 mg/dL in the face of an albumin of 2.5 mg/dL is not particularly striking, however. He did not have any radiographs of bones or gastrointestinal track in our institution. There is no evidence of renal disease here.

It would be difficult to ascribe what we see here to anything other than malabsorption. We are told that a 72 hour fecal collection for fat was not done because diarrhea "decreased on admission." It is common that diarrhea decreases when people are admitted to the hospital especially when it does not represent organic disease. I

cannot explain why this man's diarrhea disappeared but suspect the failure had more to do with resistance by personel than anything else. It is important to note that laxatives do not cause steatorrhea in the presence of a normal gut. Purging, even in the face of a massive increase in fat intake, does not result in excretion of abnormal amounts of fat in normal individuals. It is therefore appropriate to give laxatives in order to stimulate bowel movements if a fecal collection for fat is desirable. Since we did not document steatorrhea, we can only assume that it is present on clinical grounds.

A critically important test was done and was quite abnormal; namely, a xylose tolerance test. Presumably, the customary 25 grams were given orally, although this was not specified in the protocol. For the most part, urine collections for xylose excretion after absorption are subject to too many variables to be reliable, the most common of which is even mild renal insufficiency. Many of us do not bother with them. Collection of a base-line serum specimen, as here, is necessary because some substances in blood will react as xylose. It is also customary to collect only one hour and two hour serum specimens because this brackets the observed peak levels after oral ingestion in both normal individuals and those with mucosal malabsorption. A number of things can go wrong with a xylose tolerance test and the investigator must be aware of all of them to properly interpret the results. To cite an obvious one, any delay in gastric emptying will result in an abnormal test. However, one must be also aware that bacterial overgrowth in the upper small intestine routinely interferes with xylose absorption. The xylose tolerance test is important because it is reliably abnormal when the mucosa is abnormal.

To refresh our memory, table 1 diagramatically illustrates the normal process of digestion and absorption and the primary organ or system involved in each step. Notice that it is triglycerides which require every system. Our methods of determining fat absorption are reliable and well established. Measurements of protein digestion and absorption is so complex and takes so long to perform that we have essentially abandoned testing it except in children where certain congenital defects in the three separate transport mechanisms are important. Carbohydrates are so readily and rapidly absorbed that, except for specified ones such as lactose, absorption tests are difficult to interpret and tend to be unreliable indicators of absorption. Again, in children who may have specified carbohydrate transport problems, testing of carbohydrate absorption is important. We can therefore determine the causes of malabsorption in adults by examining triglyceride absorption.

The primary steps in digestion and absorption of triglycerides are lipolysis by pancreatic enzymes, solubilization by bile salts (micellerization), absorption across the mucosal cell membrane, reconstitution of the products of lipolysis (free fatty acids and beta monoglycerides) into triglycerides, formation of chylomicrons (long chain fatty acids), excretion into lymphatics and transport into the blood stream. Short chain fatty acids do not require chylomicron formation and are excreted directly into the blood stream. Clearly, pancreatic exocrine function must be intact, bile salts in critical concentrations must be present, the mucosal cell membrane must be intact, the machinery of the mucosal cell must be functioning properly, chylomicrons must be constructed and the lymphatics must be open. Defects in any step of this process leads to steatorrhea. In an unusual metabolic problem, abetalipoproteinemia, chylomicrons cannot be formed. Similarly, in intestinal lymphangectasia, the lymphatics are defective. Both of these cause steatorrhea but we have nothing to suggest their presence in our patient. There is good evidence that a lack of bile salts is not the cause of his problem unless they are being deconjugated by bacterial overgrowth. Radiographs are said to be normal and this is evidence against bacteria in the small bowel causing problems.

Tests that differentiate the types of malabsorption are really simple. A small bowel barium study defines normal anatomy of the gut and usually rules out mixing problems or diverticula associated with bacterial overgrowth. Not every patient knows what kind of surgery was performed on them and it pays to investigate. The Sudan stain, as we have discussed, is specific but insensitive and I tend not to get it. A quantitative fecal fat is both sensitive and specific but should be collected for 72 hours since fat excretion, even in normal individuals, varies considerably within short time frames. Collection of feces is not easy, however. Patients do not like the process, nurses do not like to collect it and laboratory technicians don't like to run it, all for obvious reasons. There is no substitute, however.

Serum levels of vitamin B12 and folate are very much worth while in the initial investigation but abnormal levels can be obtained in a number of problems that do not usually involve malabsorption such as pernicious anemia. Part I and II Schilling's tests may be necessary to define the cause of a low serum level of B12. Keep in mind that bacterial overgrowth also causes an abnormal Schilling's test (I and II) that is corrected by antibiotics, a so called Part III Schilling's test. Such a correction is diagnostic of bacterial overgrowth in the small intestine.

Therefore, in the initial workup, I want to know if

STEPS IN

NORMAL DIGESTION AND ABSORPTION

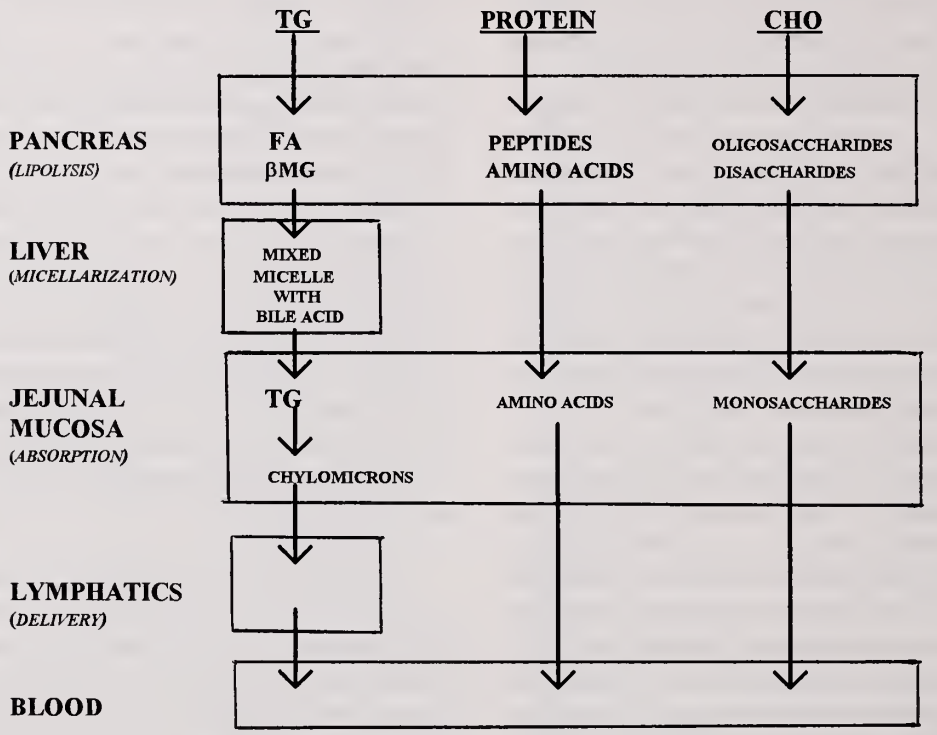


TABLE 1. TG=TRIGLYCERIDES; βMG=BETA MONOGLYCERIDES; FA=FATTY ACIDS CHO=COMPLEX CARBOHYDRATES.

TESTS TO DIFFERENTIATE

TYPES OF MALABSORPTION

A. QUANTITATIVE STOOL FAT (72 HR COLLECTION)

B. XYLOSE ABSORPTION

C. B12 ABSORPTION

D. BIOPSY OF SMALL BOWEL MUCOSA

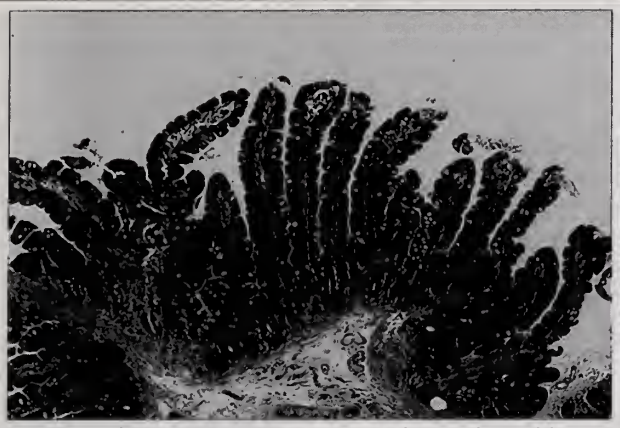




Fig. 1, left side: *Normal small bowel.* Fig. 2, right side: *Patient's biopsy showing loss of normal villous architecture.*

steatorrhea is present, if the upper GI barium studies are normal and if plain film of the abdomen shows calcium in the pancreas. If the these investigations are not helpful, I want to test the integrity of the jejunal mucosa with a small biopsy straight away and usually perform a xylose tolerance test.

The classification of malabsorption syndromes is logically divided into defects of digestion and of absorption. Digestive defects include those events that occur within the lumen of the gut and prepares nutrients for absorption. Examples of digestive defects include lack of pancreatic exocrine function that often follows chronic pancreatitis or deficiency of conjugated bile salts as by obstruction of the common bile duct, when bound by cholestryamine and by bacterial deconjugation. Bacterial overgrowth occurs in stasis in the small bowel, either in small bowel diverticula or by surgical reconstruction. Defects of absorption (and transport) include lack of bowel (short bowel syndrome), tropical and nontropical sprue (celiac disease), Whipple's disease, eosinophilic enteritis, extensive Crohn's disease, certain oral medications such as neomycin and PAS, abetalipoproteinemia, lymphangectasia, heavy infestations of giardia and many others. Steatorrhea may be idiopathic despite careful investigation. It is worth mentioning that there is a documented increased incidence of gluten sensitive enteropathy in patients with diabetes mellitus.

Considering the information given in this patient, I suspect that the diagnostic procedure performed was an endoscopic small bowel biopsy. I suppose he might have had a small bowel barium study but while that could give useful information, it would be unlikely to confirm a specific diagnosis. I believe he has celiac disease or gluten sensitive enteropathy. He does not have the joint pains that are characteristic of Whipple's disease. It is not unusual to make the first diagnosis of celiac disease in this age group despite our belief that the disease is present for a lifetime. Figure I is a normal small bowel biopsy for comparison. Figure II is a biopsy from a patient with celiac disease and I believe our patient's biopsy looks very similar. The pathologist cannot distinguish between tropical and nontropical sprue (celiac disease). The biopsies in each show identical changes. The clinician must make the distinction by history of foreign travel and carefully observing the response to treatment (antibiotics for tropical sprue and diet for celiac disease). One of the criteria for a diagnosis of celiac disease is response to a gluten free diet, often requiring several months. In the not too distant past, a symptomatic relapse was expected on testing with oral gluten as part of the criteria for diagnosis. This challange has been abandoned after noting that patients may develop shock after re-exposure to gluten. Now available to aid in the diagnosis , but not obtained in our patient, are IgA antigliadin antibodies with a sensitivity of 82% to 96% and specificity of 92% to 97% depending upon the group studied. Also available are anti-endomysial antibodies. The audience is advised to read the first reference cited below for further information on diagnostic antibodies.

Dr. Lynch: The first kodachrome is a biopsy of normal small bowel which Dr. Achord has also shown an example of just to remind everyone what normal small bowel looks like. This biopsy was actually taken from the duodenum as there are Brunner's glands in the submucosa, but the general microscopic structure is similar throughout the length of the small bowel. The surface epithelium and lamina propria form finger-like intraluminal projections called villi.

The patient's biopsy showed villous atrophy with a flattening of the surface. The lamina propria is filled with

inflammatory cells, not the foamy macrophages as seen in Whipple's disease. There is a predominance of plasma cells with lymphocytes, and often you will see the lymphocytes moving through the surface epithelium. This biopsy is typical for sprue; whether it is tropical or celiac sprue is a clinical diagnosis since we did not have nay patient history and we diagnosed this as consistent with sprue.

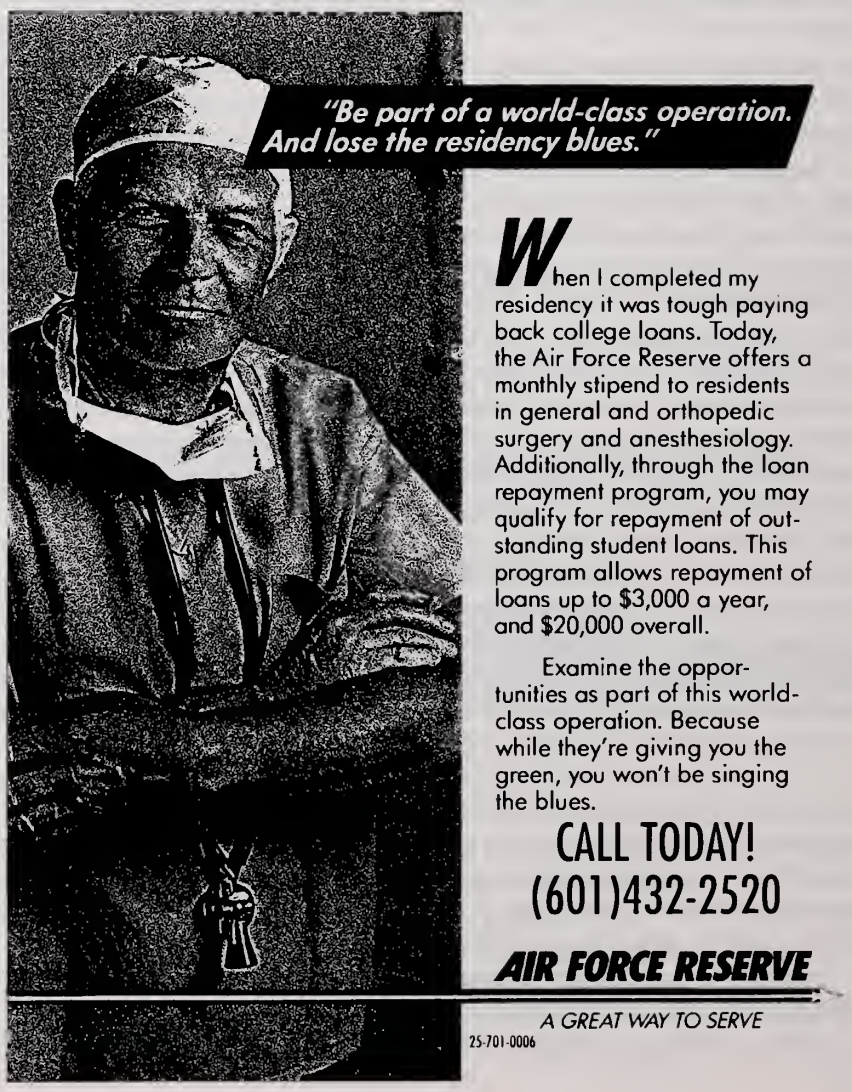
Follow-up: The patient was thought to have gluten sensitive enteropathy and stayed on a gluten free diet. At six weeks follow-up, he had already gained about 10 lbs.

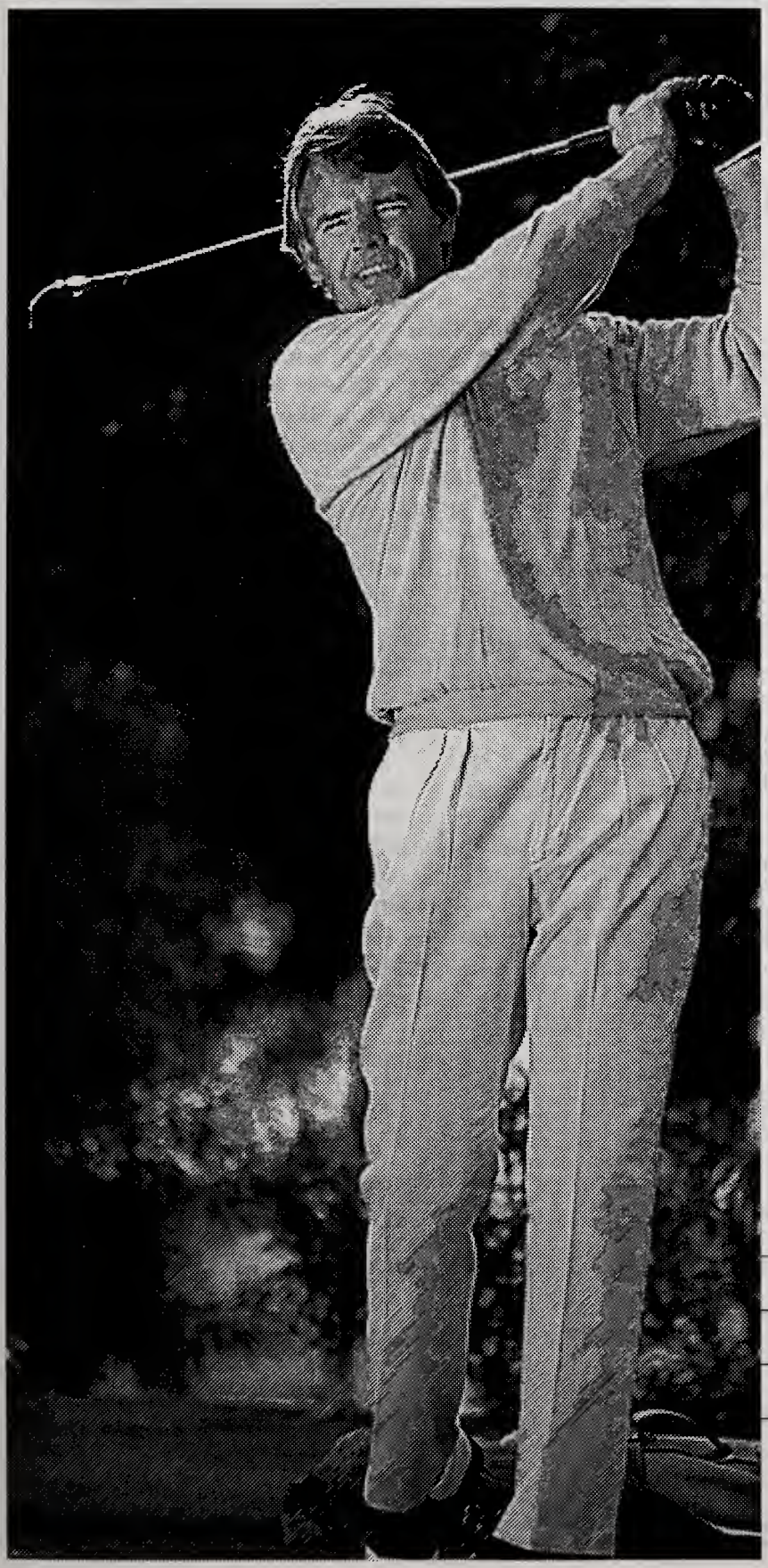
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Drs. Kubiak and Daly *were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1995-1996.*

Dr. Files *is Professor of Medicine and Interim Chair man for the Department of Medicine; Dr. Achord is Professor of Medicine; and Dr. Lynch is Chief, Pathology and Laboratory Service at the VA Medical Center.*





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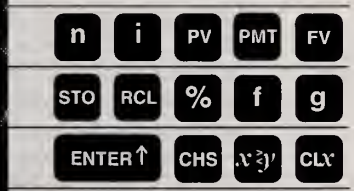
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1:00 PM	Exhibitor setup: Technical & Scientific
	MSMA Registration opens
	Coding Workshop for Physicians

THURSDAY, MAY 15

8:00 AM	Grand Opening of Exhibits - Complimentary Continental Breakfast
	MSMA Registration
	MSMA Reference Committee Breakfast
9:00	MSMA House of Delegates
11:00	Alliance Pre-Convention Board Meeting/Luncheon
11:30	View Exhibits- Complimentary Sandwich Buffet
	Committee on Publications Luncheon
12:00	Young Physicians Section Luncheon
1:00 PM	MS Foundation for Medical Care Membership Meeting
	Preview Auction Items
2:00	MSMA Reference Committee on Constitution and Bylaws
2:45	MSMA Reference Committee A
4:00	MSMA Reference Committee B
6:30	MSMA/ MSMA Alliance Membership Party

FRIDAY, MAY 16

7:30 AM	View Exhibits- Complimentary Continental Breakfast
	MS EENT Association Breakfast/Meeting
8:00	MSMA Registration
	Alliance Registration
8:30	MSMA Medicine Plenary Session
	MSMA Past Presidents Breakfast
	MSMA Alliance Welcome & Coffee
9:00	MSMA Alliance House of Delegates
12:00 NOON	MSMA Alliance Luncheon
	MS Academy of Family Physicians
	MS Neurological Society
	Presentation of Exhibit Registration Prizes- Exhibit Hall

FRIDAY, MAY 16 - Continued

1:00PM	MACM Golf Tournament - Edgewater Bay Golf Course
2:30	MSMA Alliance Post-Convention Board Meeting
5:00	MSMA Past Presidents' Reception
6:00	University of Mississippi Medical Alumni Association- MS Art Museum in Biloxi
7:00	Dinner-Mary Mahoney's

SATURDAY, MAY 17

7:00 AM	Women in Medicine Caucus Breakfast/ Meeting
	MS Chapter, ACS, Officers and Board of Governor's Breakfast
8:00	MSMA Registration
8:30	MSMA Fifty Year Club Breakfast
	MSMA Alliance Past Presidents' Breakfast
	Physicians Accessing the Internet Workshop
9:00	MSMA Surgery Plenary Session
	MS Dermatology Society
12:00 NOON	MS Chapter, American College of Emergency Room Physicians
	MS Association of Pathologists
1:00	MS Chapter, American College of Surgeons
	Physicians Accessing the Internet Workshop
3:00	MPIC - Annual Stockholders Meeting
3:30	Central Medical Caucus
6:00	MSMA President's Reception for Members and Guests

SUNDAY, MAY 18

7:30 AM	Membership Continental Breakfast
8:00	Protestant Services
9:00	MSMA House of Delegates
12:00 NOON	Meeting adjourns

"Current Trends in the Health Care Environment"

EDUCATIONAL PROGRAM

(PRELIMINARY SCHEDULE)

PLENARY SESSION

Friday, May 16 • Room B

9:00 AM "Case Dissection: The Anatomy of a Claim"
Robert M. Jones, J.D.
Medical Assurance Company of Mississippi

10:00 AM "Health Care Issues in the New 105th Congress"
Mr. Scott Wilber, Director
AMA Washington Office

10:40 AM "Trends in the Health Care Workforce"
Marvin Dunn, M.D., Secretary
AMA Council on Medical Education

11:15 AM "Physician Supply and Medical Education Issues"
W. Douglas Skelton, M.D., Dean
Mercer University School of Medicine

Noon Adjourn

PLENARY SESSION

Saturday, May 17 • Ballroom B

9:00 AM "A Regional Trauma System for Mississippi"
- "Current and Future Plans"
  Ed Thompson, M.D., State Health Officer
  MS State Department of Health
- "Role and Experience of a Tertiary Center"
  Keith Thomae, M.D., Assistant Professor of Surgery
  University of Mississippi Medical Center
- "Operation in Rural Mississippi"
  Hugh A. Gamble, II, M.D.
  Gamble Brothers and Archer Clinic, Greenville, MS

10:30 AM "Consumer Protection and Managed Care "
Honorable George Dale, Commissioner of Insurance
State of Mississippi

11:10 AM "Medicaid's Managed Care Program-Past Experiences / Future Plans"
Helen Weatherbee, J.D., M.P.H., Director
Mississippi Medicaid Program

12:00 Adjourn

Plenary Programs Planned by MSMA's:
Council on Scientific Assembly

TECHNICAL EXHIBIT

MSMA 129th Annual Session

EXHIBITORS (as of JOURNAL MSMA Press Date)

Abbott Laboratories
Affiliated Consultants, Inc.
American Medical Recruiting Co.
Apex Healthcare of MS, Inc.
Companion Technologies
Continue Care Home Health
Executive Planning Group
Foundation for Medical Care
Global Health Resources
Health Link
Horne CPA Group
I-Stat Corporation
Magnolia Health Plan
Medical Assurance Company of Mississippi
Medical Pathology Laboratory, Ltd.
Memorial Hospital at Gulfport
Merck & Company, Inc.
Millcreek Rehabilitation Center
MS Academy of Physician Assistants
MS Army National Guard
MS Health Sciences Information Network
MS Methodist Rehabilitation Center
MSMA Benefit Plan & Trust
MS Organ Recovery Agency
MS Physicians Care Network
MS Physicians Insurance Corporation
MS State Department of Health
Mutual Assurance Inc.
Pfizer Labs, Inc.
Physicians' Advantage
Pine Grove Hospital
Puckett Laboratory
Rush Foundation Hospital
RX Manufacturing
Sanofi Pharmaceuticals
Southern Medical Association
St. Paul & Marine Insurance Company
Sta-home Health Agency
THE DOCTORS' COMPANY
TeleVox Software, Inc.
The PIE Mutual Insurance Company
The Reciprocal Group
United Health Care
United HealthCare - Medicare B
US Air Force
US Army Health Care Recruiting
Whispering Pines Hospice



Mississippi State Medical Association Alliance

74th Annual Session
May 14-18, 1997
Grand Casino Hotel
Biloxi, MS

WEDNESDAY, MAY 14

3:00 PM - 5:00 PM	Registration - 2nd Level

THURSDAY, MAY 15

9:00 AM - 4:00 PM	Registration - 2nd Level
11:00 AM	Pre-convention Board Meeting/Luncheon
1:00 PM - 5:00 PM	View AMA-ERF Auction items
6:30 PM	MSMA/ MSMAA Membership Party & AMA-ERF Auction

FRIDAY, MAY 16

8:00 AM - NOON	Registration - 2nd Level
8:30 AM	Alliance Welcome and Coffee
9:00 AM	House of Delegates
12:00 PM	Luncheon/ Installation of Officers
2:30 PM	Post-convention Board Meeting

SATURDAY, MAY 17

8:30 AM	MSMAA Past Presidents' Breakfast
6:00 PM	MSMA President's Reception



Fred L. McMillan, M.D.

The President's Page

Quo Vadis
(Where Are We Going?)

So the big question, regarding membership in the Mississippi State Medical Association, now is not why belong to the MSMA but, why belong when dual membership in the American Medical Association is a requirement?

The issue of mandatory membership in the AMA was first brought before the House of Delegates in 1985. All aspects, pros and cons, were discussed in the Reference Committee and on the floor of the House of Delegates at that time. The resolution passed with no dissenting vote. Since then the issue for deunification has come up twice, once in 1989 and again in 1994. Each time the Delegates voted unanimously to remain unified.

The staff over the past couple of years has received an increase in the number of complaints on the issue of unification as more physicians are considering joining MSMA - partly because of the desire to belong to the association sponsored Mississippi Physician Care Network (MPCN). As a result of this, the Board of Trustees has asked all of the physicians in the state, members and nonmembers as well, to voice their opinion on this issue. Hopefully, there will be a thorough and informed discussion at MSMA's annual meeting in May followed by a definitive vote to determine the best direction for the MSMA to take for the benefit of Mississippi physicians collectively. I have always believed that an informed group makes a decision that is best for the group as a whole.

The only reason I can give for not requiring AMA membership is the initial reticence I have to make anything mandatory. Another problem I had to work through twelve years ago is that, no doubt, sometimes the AMA House of Delegates decides on a course of action that is not best for me personally, or sometimes for my surgical specialty, i.e. ophthalmology; however, we are always in situations where the good of the majority on one issue might not be what we would like to see happen. This is true whether it is our family, church, community, etc. We do not use a litmus test on any one single issue to decide our belonging to these and we must be careful not to do the same with

our professional organizations.

We must be sure that we are talking about realities and not about perceptions told as "truth" in the Doctor's Lounge. We must be sure stones are cast in the right direction for it is too easy to mistake our parent organization, the AMA, to be at fault when, in fact, the leaders are having to attempt to move issues in the direction we have said we want (the members through the Delegates) in the face of the realities of the desires of much larger and/or stronger groups, society as a whole, news media, AARP, AFL-CIO, insurance companies, and don't forget the politicians. All of these desire to put the spin in their best interest. One thing we as physicians have in our favor, more than anyone else and must always keep in focus, is our patient advocacy. Putting the patient first is always in our best interest. It may not always play best in the news and on Capitol Hill but over time it has always won. No other organization does this like the AMA, while at the same time being sure that it does not go unnoticed when physicians' rights are trampled.

To the specialists that think the AMA is run by family practitioners- think again. Specialists outnumber primary care physicians 318 to 119 in the House of Delegates. The Board of Trustees has six physicians practicing in a specialty area while seven are in family practice or internal medicine. The President of the AMA is a radiologist and specialists outnumber the primary care physicians on the elected and appointed councils 49 to 27. The fact is that both the AMA House of Delegates and the AMA's elected leadership are a reflection of the physician population of the U.S. In addition, Mississippi has reached a level of influence in the AMA never seen in its history with Ed Hill serving on the AMA Board of Trustees and three other physicians serving on councils of the AMA. Unification has certainly helped give each MSMA member a direct voice to the leadership of the AMA. The AMA is also currently undergoing a reorganization as a federation so that all physicians who belong to the AMA are given more representation according to their area of expertise.

We need and must have a strong national organization speaking for us on broad issues. Regardless of what we might read or think, there is simply no organization representing physicians across the board with the attention and respect of the national policy makers that the AMA enjoys. The AMA is launching a new public information campaign to let the world know of all of the good things physicians are doing through the AMA and particularly how we advocate effectively on behalf of our patients. There will be ads in the *Wall Street Journal, New York Times, Washington Post, Time, Newsweek,* etc. This new program will also better focus the AMA on its mission which has become increasingly complex, desperate, and on occasion conflicting in policies.

The AMA is important to physicians every day. Who accredits our medical schools? Our hospitals? Our national specialty organizations? THE AMA! Who constantly reviews and sets the standards for the ethical practices of medicine? THE AMA! Who is looked upon by policy makers as the national voice of physicians on matters of national medical policy? National credentialing? THE AMA! The AMA is the organization that supports national candidates that understand quality health care is hanging in the balance, provides daily support for the MSMA staff, and institutes national ad campaigns.

So is the AMA worth the $420.00 per year on a cost/benefits basis? For those of us that belong to the AMA, and therefore, support its national policy, financially, we are paying for a free ride of those that do not belong. The fact is we can not practice medicine in the U.S. without an organization like the AMA and there is no one else around to replace it. I have been a continuous member of the American Association of Physicians and Surgeons (AAPS) for as long as I have been a member of the AMA - I joined both when I opened my practice in 1974.

The second question is: Should Mississippi make it mandatory that all members belong to the AMA? I know my answer - yes. The Reference Committee will take up the issue Thursday, May the 15th. All members may participate in the reference committee meetings and it is not difficult to become a Delegate - just ask your component society. So come to Biloxi, May 15th - 18th and let us hear your thoughts on this important issue.

Fred



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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 4
APRIL 1997

Limiting Access To Tobacco Products

Year: 1959
Place: UMC classroom
Event: Surgical Grand Rounds
Speaker: Alton Oschner, M.D.
Subject: Cigarette Smoking and Lung Cancer

Although it has been thirty-eight years since the above event I vividly recall that presentation. As a medical student this was my introduction to the health related effects of smoking. Having spent the first fifteen years of my life in the North Carolina tobacco belt, and being from a family with multiple tobacco farmers, it came as a shock that there were significant health hazards associated with cigarette smoking.

Doctor Oschner continued his campaign on the causal relationship between cigarette smoking and lung cancer until his death. Unfortunately his message was not readily received or appreciated, but his persistence subsequently led to a more profound understanding of the detrimental effects of smoking. Twenty-five years later a "HAZARDOUS TO YOUR HEALTH" label was mandated on cigarette packaging. Approximately thirty years later we began to see the control of smoking in public places, and this has now progressed to significant restrictions in restaurants, airliners, and multiple other public accommodations and facilities. Now, thirty-eight years later, the Food and Drug Administration has declared nicotine to be a pharmacologically addictive agent and is currently using this declaration as an enforcement tool against the distribution of tobacco products. Proposed regulations are currently scheduled to become effective on February 28, and August 28, 1997. At this time the tobacco industry is involved in litigation to overturn these proposals on the grounds that the Food and Drug Administration lacks the constitutional authority to enforce these regulations. Multiple state have now passed regulations restricting the sale of tobacco products to anyone under eighteen years of age. Several states are now pursuing litigation against tobacco companies for recovery of the enormous cost related to treating the illnesses associated with smoking in the Medicaid population.

There are approximately 45 million smokers in the U.S. and 430,00 potentially preventable smoking related deaths annually. Smoking remains the single most important cause of cancer in this country, and smoking related illnesses account for approximately thirty percent of all deaths. Eighty-five percent of lung cancer deaths, and an equal percentage of cases of chronic obstructive pulmonary disease, are smoking related. It is a significant etiologic factor in arteriosclerosis and twenty percent of deaths from cardiovascular disease are smoking related. Oral disease, laryngeal, and pharyngeal cancers are all associated with smoking. More recently reproductive disorders have been associated with smoking. While the list gets longer cigarette smoking continues to be the principal cause of preventable disease, disability, and premature death in our society, and the estimated cost of smoking related medical care in this country is sixty billion dollars annually.

The distribution of smoking between the sexes is now nearing equal levels, thus reflecting the steady increase in female smokers over the past thirty years. The level of female teenage smoking is now slightly higher than in males, with both groups increasing. Since most adult smokers begin smoking in their teenage years the current goal of national and state regulations is the restriction of access of tobacco products by teenagers. The Food and Drug Administration has referred to documents from the industry showing that tobacco products are designed to be pharmacologically active

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

agents, and advertising is directed to the teenage and younger adult groups.

With all the documented health problems associated with cigarette smoking one must ask why it has taken almost forty years to begin to see any significant activity in curtailing tobacco usage, thereby reducing the enormous major medical problems and economical loses associated with the use of tobacco products. Currently HB 1389 is making its way through the Mississippi Legislature and has passed the House. It has now been sent to the Senate. This bill, limiting access to tobacco products by anyone under eighteen years of age, has been strongly supported by your Association. If passed by the Senate, subsequently signed into law, and properly enforced, this will become one of the most significant health related bills passed by our Legislature, and will profoundly improve the health of the citizens of this state.

Myron W. Lockey, M.D.
Editor

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MORA Improves Organ and Tissue Donor Referral System

A significant improvement has been made to simplify the donor referral process. Mississippi Organ Recovery Agency (MORA) and Mississippi Lion's Eye and Tissue Bank are utilizing a new service that is designed to help simplify and improve the donor referral process for our region's hospital staff. Now all calls to the central donor referral number will be routed through STATline, a new organization formed to provide immediate and professional response to each donor referral. The central referral phone number remains the same, 984-5030 or 800-362-6169. Trained referral specialists will answer each call promptly with information and donation options based on the donor situation. They will also rapidly contact the appropriate recovery organization and place each caller in contact with the local organ or tissue recovery coordinator if needed. The coordinator staff from each of the two organizations will continue to provide rapid on-site assistance and clinical services within the hospitals.

We hope the new service will provide improved and rapid services to donor hospital staff who are the key link to successful organ and tissue donation in this state. With the elimination of paging delays and the rapid assessment of donation options, the referral process will be easier for all callers.

We realize hospital staffs are increasingly busy. This new phone referral system will reduce the demands and time required to make that very important call. The Mississippi Organ Recovery Agency and Mississippi Lion's Eye and Tissue Bank appreciate physicians continued involvement and support of organ and tissue donation programs. It is only with such interest and assistance that the donation option can be provided to families and successful transplantation of organs and tissues can be accomplished.

50th Anniversary Celebration Kick-Off

On the morning of May 7, 1847, 268 delegates, representing medical societies and institutions from 22 states, assembled in the hall of the Philadelphia Academy of Sciences to approve a Code of Ethics for the organization that was to call itself the American Medical Association. The AMA Code, the first national code of medical ethics, set standards for physician behavior and became a model and emulated around the world.

To commemorate that historical event, the AMA sponsored a sesquicentennial ethics conference in Philadelphia March 14-15. This conference of physicians, bioethicists and historians met to reflect on the progress of medical ethics past, present and future. It's focus was the changing moral legal and economic pressures on the AMA Code and the difficult choices facing the profession as it heads toward the twenty-first century

New Clinical Practice Guideline on Alzheimer's Disease Released

A new clinical practice guideline, *Recognition and Early Assessment of Alzheimer's Disease and Related Dementias,* sponsored by the Agency for Health Care Policy and Research (AHCPR), helps clinicians identify changes in an individual that might be symptoms of Alzheimer's disease and other dementias, and provides the tools needed to conduct an initial assessment when these changes or symptoms are present.

Alzheimer's disease and related dementias, which affect as many as 4 million Americans, often go unrecognized or are misdiagnosed in their early stages. Many health care professionals, as well as patients, their families and friends, mistakenly view the early symptoms of dementia as inevitable consequences of aging.

This new guideline, developed by a multidisciplinary panel of experts, urges clinicians and patients to be aware of symptoms such as increased difficulty with the following: learning and retaining new information, handling complex tasks, reasoning, and spatial ability and orientation. According to the guideline, these symptoms should trigger a clinical assessment. A family history of dementia and/or Down syndrome are possible risk factors that also merit special attention.

Copies of the full guideline may be purchased from the Government Printing Office, at 202-512-1800. For copies of the quick reference or consumer guides, call the AHCPR Publications Clearinghouse at 800-358-9295. To access all of the Alzheimer's disease guideline documents on-line, go to AHCPR's home page on the World Wide Web at http://www.ahcpr.gov/guide and select "Clinical Practice Guidelines Online."

In Memory

Dr. James Thomas Thompson, a past president of MSMA, died at his home in Moss Point, Mississippi on March 1, 1997.

A respected community leader, Dr. Thompson at various times served on the board of directors of Merchant Marine Bank of Moss Point, on the County Election Commission, as president of his local Chamber of Commerce and as president of the Moss Point Rotary Club. He was credited with making many contributions toward the growth of the Singing River Hospital System and served on the hospital's Board of Trustees. He was a member of the First Baptist Church of Moss Point, where he was a deacon, chairman of the deacons and trustee for many years.

Dr. Thompson was born in Houlka, Mississippi on November 5, 1904. After graduating from Mississippi College, he earned his M.D. degree at the University of Tennessee Medical School and completed surgical training at the University of Chicago. He began his medical-surgical practice in Moss Point in 1940, where he initiated construction of the area's first hospital. He was an active member and past president of the Coast Counties Medical Society and a member of the Board of Trustees of the Mississippi State Medical Association before becoming president in 1966-67.

Letter

Inverness Medical Clinic, Inc.
814 East Grand Ave.
P.O. Box 247
Inverness, MS 38753

January 13, 1997

Mr. Charles Mathews
Executive Director,
Mississippi State Medical Association
P.O. Box 5229
Jackson, MS 39296-5229

Dear Editor:

In my area (the Delta) prescriptions written by nurse practitioners are given the title of doctor in front of their name by the pharmacy. Also, x-rays and lab reports are frequently titled by doctor as the referring individual. In addition to the above, some pharmaceutical companies address them as M.D. in correspondence.

I can understand their patients calling the nurse practitioners doctor, as they serve in place of a physician. What I cannot understand is that the pharmaceutical companies and their representatives as well as hospital labs and x-ray departments title them as doctor. These people should know the difference.

I wonder if any other physicians have noted this and are they concerned or unhappy with it

Sincerely,
Arthur E. Wood, Jr., M.D.

ATTENTION

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Giselle Moore, MSN - *Quality of Life Issues in the Management of Head & Neck Cancer*
Daniel Petereit, MD - *Cervical Cancer: Management Controversies*
Darryl C. Hunter, MD - *Outcomes Mgmt: Guiding HealthCare Through Troubled Waters*
Stratton Hill, MD - *Pain Management*
Robert Kuske, MD - *Radiotherapy Applications to Nonmalignant Vascular Disease*

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The Homochitto Valley Medical Society met at Monmouth Plantation in Natchez, Thursday evening, March 6, 1997. Shown at the dinner, left to right, *Dr. and Mrs. (Dale) David R. Steckler, MSMA Assistant Executive Director and Legal Counsel Bill Roberts, Mrs. Mallan G. (Lana) Morgan, and MSMA Director of Government Affairs Charmain Thompson.*

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Left to right: *Dr. Mallan G. Morgan and MSMA President Dr. Fred L. McMillan listen to Dr. Thomas L. Purvis, Jr.*

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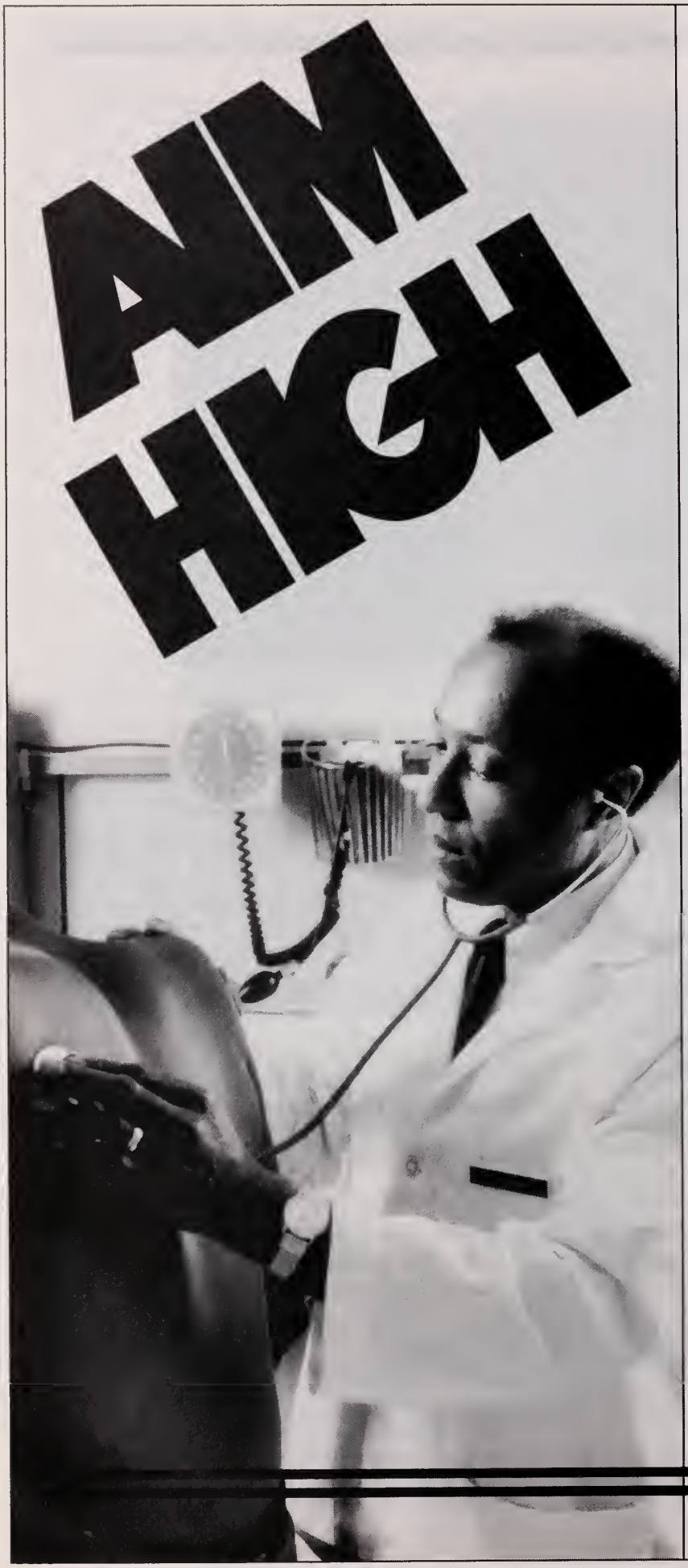


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AIR FORCE

Tax Reform and Physician Services

Various proposals for reforming the federal income tax system have been advanced in recent years. Some proposals would eliminate virtually all income tax deductions, including those for health insurance premiums. Others would replace taxes on income with taxes on consumption. Elements of these proposals could raise the price of health care to consumers and, ultimately, the level and mix of health care expenditures. While it is too early to forecast when tax reform will occur, let alone the form it may take, it would be well to consider some of the ramifications such changes might have for the health care market, particularly that for physician services.

I. Background

The current tax treatment of insurance and health care expenditures can be briefly described as follows. For employers who provide insurance for their workers, premiums are a tax-deductible expense. Their employees do not have to count these employer-paid premiums as income; whether they can deduct some or all of their employee shares (if any) of premiums depends on the benefit plan design. Approximately 60% of persons between the ages of 18 and 64 are employees who have insurance, so this represents by far the biggest block of persons that would be affected by tax reform. Individuals who purchase their own insurance and pay their own premiums have to do so with after-tax dollars. Individuals who itemize on their federal tax returns can only deduct out-of-pocket costs and self-pay premiums if they exceed 7.5% of adjusted gross income, fewer than 2% of filers qualify for this deduction. Self-employed persons currently can deduct only 30% of insurance premium costs from taxable income, compared with 100% for workers with employment-based insurance.

II. Tax Reform Proposals

The two reform proposals that have attracted the most attention are the flat tax and the consumption tax.[1] These reforms would have in common the effect of giving individuals more cost consciousness about their health insurance and health care consumption decisions, though that is not the primary reason the proposals were brought forth. Many variants of the flat tax and consumption tax have been proposed.[2] The discussion that follows is based on simplified versions that do not allow deductibility of health policy premiums or out-of-pocket expenditures.

An issue is whether a given proposal would be tax-revenue-neutral. To avoid exacerbating the federal budget deficit, the government has a strong incentive not to create new sources of "tax expenditure." Therefore, it is likely that aggregate tax payments would be revenue-neutral in the first year of enactment. Even so, because the form of taxes and the point at which they are paid would be different than now, significant changes are likely to occur in the pattern of demands for health insurance and health care services.

Flat tax. A flat tax would eliminate most, if not all, current deductions. Employers would no longer be able to deduct health insurance benefits for employees as a business expense, and would have to pay income and payroll taxes on the value of noncash compensation other than retirement benefits. For individuals, taxable income, after substantial personal exemptions, would be taxed at a single rate of approximately 17-20%.[3] If the purchase of health insurance (and, to a lesser extent, out-of-pocket expenditures) were no longer subsidized, the true cost to the purchaser would rise. (The consumer-patient should be regarded as the ultimate purchaser, even in situations in which insurance is provided as a fringe benefit of

employment. Economists regard fringe benefits as a substitute for cash wages.)

Consumption tax. A consumption tax in the form of a national sales tax would not tax income at all. Rather, consumption would be taxed at the point of retail sale; one proposal suggests a rate of 15% (Schaefer 1996). Expenditures on health insurance and medical care would be considered consumption. Consumer-patients would have more disposable income, but purchases of health insurance through employers would not be subsidized. Whether the price of health care to the consumer-patient at the point of purchase would rise or fall depends on the size of the sales tax relative to the foregone subsidy and the degree to which more disposable income would generate additional demand for health care. In all likelihood, however, the quantity of health care delivered would be lower under the sales tax regime than under the current tax system.

The purchase of most health insurance and the expenditure of some out-of-pocket funds for health care would no longer be subsidized. Since the price of health care at the point of purchase would effectively rise, the quantity of health care demanded would likely decline.

Two other proposals have been advanced that do not represent fundamental tax system reform, but which nevertheless could affect the demand for health care. Medical savings accounts would allow the tax deductibility of individual health expenditures. A medical savings account is an annually supplemented pool of funds that is earmarked for health care expenses. Employers that currently fund such accounts do not receive the same tax treatment as when they provide traditional health benefits; most proposals promoting medical savings accounts would provide for some sort of tax preference. When coupled with high-deductible insurance policies, it means that patients face full charges at the point of purchase, with protection against catastrophic expenses. Under a health care voucher system, a voucher would be provided by employers in lieu of health care benefits to employees who want to take care of their own expenses; employees would then purchase an insurance policy elsewhere. It has been proposed that vouchers receive the same favorable tax treatment as employer-provided insurance does.

III. How Tax Law Changes Might Affect Health Care Markets

The effects of proposed tax reforms on health care markets has not been estimated quantitatively. Nevertheless, how the physician services market may react can be discussed in qualitative terms using the tools of economic analysis. Because many details will have to be worked out in implementing a change, the discussion must be speculative. No distinction will be made here between the flat tax and consumption tax systems because their effects on the price of insurance and the price of health care are fundamentally similar.

With the removal of favorable tax treatment of health insurance, the most obvious first-order effect is that the demand for employment-based insurance would fall. Some employers would stop providing insurance and give their employees more cash income; others might provide policies that covered less services. The price of a given policy would also fall, partially mitigating the decline in the quantity of insurance demanded. A few consumer-patients with very high out-of-pocket health care expenses would lose their ability to deduct them, but this segment is so small that little effect would be expected on the market demand.

Not only would the aggregate amount of insurance probably fall, the form of insurance would be expected to change. For instance, consumers would turn more toward policies with high deductibles and low premiums in which they would pay out-of-pocket for routine office visits, prescriptions, and so on, while retaining insurance against rare occurrences of unexpectedly high costs of care associated with "catastrophic" illnesses. Other types of changes may be expected as well, such as: insurance policies that cover less benefits; the choice of HMOs as a lower cost substitute for indemnity insurance[4]; and some purchasers going without third-party insurance altogether.

Given that consumer-patients would pay more from their own pockets, they would become more cost conscious. They would be expected to do more "shopping around" for health care than they do currently before making a decision on whether and from whom to seek care. Although the aggregate amount of health care consumed would be expected to fall, there are several reasons to suppose that the fall may not be far. A change in the tax code will not alter the epidemiological profile of consumer-patients. They still are going to solicit the advice of those with the most knowledge (i.e., health care providers) before making a decision. (A slight increase in consumer self-education on health care is to be expected). Finally, once the decision to get care has been made, the vast majority are still likely to get it from a health care professional, compared with alternatives.

IV. Effects on Physicians

Some implications for the physician services mar-

ket can be deduced. A reduction in the aggregate amount spent on physician services is to be expected. The reduction in the amount spent per period (relative to what would have been spent under the current tax regime) should be small immediately following that tax system change, becoming somewhat larger in later periods as consumers adapted. The reduction is expected to be larger for routine office visits and other types of care that tend to be of lower cost and greater predictability. The demand for less frequent, higher cost services may not change much if consumers retain insurance against these events. Consistent with the notion of increased information gathering, consumers may spend more time consulting with physicians about treatment alternatives.

The discussion in the previous paragraph suggests that a reduction in total practice revenue per physician would be expected initially. Changes on the physician supply side of the market are likely to occur as well. With revenues being squeezed, physicians would look for ways to trim practice expenses, which is even more likely to take place if the overall scale of the practice declined. Innovations in medical care cost containment would reinforce these trends. Expense savings would offset the fall in revenues, mitigating the drop in after-expense net income. A change in the mix of services can be anticipated as well, with less routine office visits and more consultations and treatments for serious illnesses. Eventually, a change in the physician specialty mix would be expected to follow. Over the long term, the physician workforce would adjust downward relative to its historical trend, so that the expected return to an investment in medical education might not differ much from what it is currently.

V. Summary

Reform of the federal income tax system that eliminated the current subsidies for health insurance purchases would likely alter both the magnitude and form of the demand for physician services. Although quantitative estimates of the effects are yet to be made, it is possible to make qualitative predictions using economic theory. Changes in the type of insurance purchased by consumers would likely lead to changes in the mix of services away from highly predictable, low cost services and toward less predictable, high cost services as well as more consultations. The physician specialty mix may well change in the long run, as will the size of the physician workforce relative to the population. Eventually, the financial attractiveness of medicine may not differ greatly from what it is now.

Endnotes

[1] For a more complete description of these proposals along with a list of their purported advantages, see Mitchell (1996) on the flat tax and Schaefer (1996) on the national sales tax form of a consumption tax.

[2] A description of the tax treatment of many employee benefits under present law and various tax reform proposals is contained in Salisbury (1995).

[3] The proposal introduced by Rep. Armey and Sen. Shelby would lower all tax rates to 20% initially and to 17% beginning in 1998.

[4] The product offered by HMOs would also likely change. Since they essentially offer first-dollar coverage, HMO products as currently configured would become relatively more expensive. HMO plans would probably adapt by reducing the generosity of benefits in some fashion in order to lower their products' prices and retain market share.

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1. Mitchell, Daniel. The Flat Tax: Freedom, Fairness, Jobs, and Growth. The Heritage Foundation. Washington, DC: Regnery Publishing, Inc., 1996.
2. Salisbury, Dallas L. "Employee Benefits in a Flat Tax or Consumption Tax World." Employee Benefit Research Institute Notes, Vol. 16 (September 1995): 1 -11.
3. Schaefer, Dan. "The Case for a National Sales Tax." The Wall Street Journal. March 11, 1 996.

Source: American Medical Association Center for Health Policy Research

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Stroke Management Project Shows Findings

Findings have been compiled in the Foundation's Stroke Management Quality Improvement Project.

Data collection in the project, which began in 1994, included a review of the charts of Medicare beneficiaries discharged from four participating hospitals between July 1, 1992, and June 30, 1993.

Results of the data analysis provided a baseline for the four hospitals and showed areas for improvement. Interventions were implemented by the providers, and follow-up monitoring was performed on discharges which occurred between May 1, 1995, and April 30, 1996.

The baseline study consisted of 375 patients; 334 patients were in the follow-up study. Indicators were developed utilizing the American Heart Association Guidelines for the Management of Patients with Acute Ischemic Stroke. A local study group also provided input in the development of the indicators. The quality indicators included:

- CT scan within 24 hours
- Deep vein thrombosis (DVT) prophylaxis
- Evaluation for potential source of emboli
- Use of preventive therapy at discharge (warfarin, aspirin and ticlopidine)
- Avoidance of emergent treatment of blood pressure. (Specifically sublingual nifedipine)

Statistically significant improvement was found in several of the indicators.

A summary of the findings for the hospitals participating in the project include:

- Initial CT scan within 24 hours, up 17 percentage points to 97 percent;
- Diagnostic chest X-ray, up 11 percentage points to 85 percent;
- CPK tests up from 21 percent to 27 percent;
- For DVT prophylaxis, use of at least one indicated therapy, up from 38 percent to 52 percent;
- To evaluate potential source of emboli, the use of cardiac ultrasound increased from 45 to 56 percent, and the use of cerebral angiogram/MRAs increased from 5 to 19 percent;
- Use of warfarin at discharge increased from 23 percent to 29 percent; the use of warfarin, aspirin or ticlopidine increased from 67 to 76 percent;
- The percent of patients with emergent blood pressure treatment fell from 32 to 6 percent; of those patients, the use of sublingual nifedipine fell from 92 to 70 percent.

The high incidence of stroke in the state indicated the importance of the project. Statistics reflected that in 1991 out of 142,562 Medicare acute care Prospective Payment System admissions, 4,609 were Medicare patients with a principal diagnosis of stroke.

The project was developed under the Health Care Financing Administration's Health Care Quality Improvement Program.

Trannie Murphy, RRA, serves as project manager. For further information, contact her at 601-354-0304. Note: May is annually observed as

Stroke Prevention Awareness Month. The Mississippi Stroke Education Consortium (MSEC) with the mission of decreasing the stroke-related morbidity and mortality in the state through education will again be sponsoring events for the special month. MSEC members include the American Heart Association, Mississippi Affiliate, the University of Mississippi Medical Center, the Foundation and the Mississippi State Department of Health.

James S. McIlwain, M. D.
Principal Clinical Coordinator

The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.



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ADAMS, JOSEPH A., Jackson. Born July 5, 1966; MD State University of NY at Buffalo School of Medicine, Buffalo, NY 1991; ophthalmology residency University of Texas Southwestern Medical Center, Dallas, TX, 1991-95; fellowship in pediatric ophthalmology, Children's National Medical Center, George Washington University, Washington, DC, 1995-96; elected by Central Medical Society.

ARNOLD, ANITE L., Oxford. Born Memphis, TN, June 27, 1958; MD University of Tennessee College of Medicine, Memphis, TN, 1993; internal medicine residency, same, 1993-96; elected by North MS Medical Society.

BALDWIN, NATHAN W., Booneville. Born Tupelo, MS, June 9, 1964; MD University of Tennessee College of Medicine, Memphis, TN, 1992; internal medicine and pediatric medicine residency, Same, 1992-96; elected by Northeast Medical Society.

BENGE, J. PATRICK, Booneville. Born Houston on March 24, 1965; MD University of Kentucky College of Medicine, Lexington, KY, 1992; Ob-gyn residency, Tulane Medical Center, New Orleans, LA, 1992-1996; elected by Northeast MS Medical Society.

CORSON, RICHARD H., Batesville. Born Woodbury, NJ, November 2, 1931; MD Temple University School of Medicine, Philadelphia, PA, 1957; ob-gyn residency, Jackson Memorial Hospital Medical Center, Miami, FL, 1963-67; elected by North MS Medical Society.

CRECELIUS, LAURA JANE, Booneville. Born Evansville, IN, April 20, 1966; MD Indiana University School of Medicine, Indianapolis, IN, 1992; ob-gyn residency, University of Tennessee Medical Center, Memphis, TN, 1992-96; elected by Northeast MS Medical Society.

DELLINGER, GREGORY W., Corinth. Born Corinth, MS, May 18, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine and gastroenterology fellowship, same, 1991-96; elected by Northeast MS Medical Society.

FIGUEROA, ALFREDO H., Jackson. Born Quito, Ecudor, February 18, 1955; MD Universidad Central South America Medical School, Quito, Ecuador, 1980; internal medicine residency, University Medical Center, Jackson, MS 1983-86; fellowship in pulmonary medicine, same, 1983-86; cardiology fellowship, same, 1988-91; elected by Central Medical Society.

GISPEN, JEAN G., Oxford. Born Oxford, MS, December 9, 1954; MD Duke University School of Medicine, Durham, NC, 1975-79; internal medicine residency, Vanderbilt University Medical Center, Nashville, TN, 1979-82; rheumatology fellowship, University of Alabama - Birmingham, Birmingham, AL, 1982-84; elected by North MS Medical Society.

HENDERSON, ANITA S., Hattiesburg. Born Nairobi, Kenya, September 14, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; pediatric residency, Vanderbilt University Medical Center, Nashville, TN 1991-94; elected by South MS Medical Society.

LIEBERMAN, PHILLIP L., Southaven. Born Memphis, TN, March 20, 1940; MD University of Tennessee College of Medicine, Memphis, TN, 1965; internal medicine residency, same, 1966-69; allergy and asthma fellowship, Northwestern Medical Center, Chicago, IL 1969-71; elected by Desoto County Medical Society.

McKINNEY, ROBERT H., Booneville. Born Baldwyn, MS, September 8, 1966; MD University of Tennessee School of Medicine, Memphis, TN, 1992; internal medicine & pediatric residency, same, 1992-96; elected by Northeast MS Medical Society.

MOORE, C. DAMON, Byhalia. Born Memphis, TN, February 19, 1964; MD Johns Hopkins University School of Medicine, Baltimore, MD, 1992; pediatric residency, University of Washington Affiliated Hospitals, Seattle, WA, 1992-95; elected by North MS Medical Society.

MOORE, CHARLES K., Jackson. Born Kokomo, IN, October 30, 1957; MD St. Louis University School of Medicine, St. Louis, Mo, 1984; internal medicine residency, Duke University Medical Center, Durham, NC, 1984-87; fellowship in cardiovascular diseases, University of Michigan Medical Center, Ann Arbor, MI, 1987-89; elected by Central Medical Society.

OVERMYER, KENT T., Gulfport. Born Ft. Wayne, IN, July 31, 1962; MD Indiana University School of Medicine, Indianapolis, IN, 1991; anesthesiology residency, same, 1992-95; fellowship anesthesia pain management, same, 1995-96; elected by Coast Counties Medical Society.

PICKARD, PAUL W., Jackson. Born Manila, Philippines, November 30, 1961; MD University of South Alabama School of Medicine, Mobile, AL, 1988; anesthesiology residency, same, 1988-92; elected by Central Medical Society.

PUPA, SANDRA H., Meridian. Born Illinois, June 27, 1958; MD Wright State University School of Medicine, Dayton, OH, 1985; radiology residency, Brooke Army Medical Center, San Antonio, TX, 1985-90; elected by East MS Medical Society.

SCURRIA, PHILIP L., Vicksburg. Born August 18, 1959; MD Louisiana State University School of Medicine, New Orleans, LA, 1986; psychiatry residency, same, 1986-90; elected by West MS Medical Society.

SNEED, RAPHAEL C., Jackson. Born Alabama, December 2, 1942; MD University of Alabama School of Medicine, Birmingham, AL, 1968; pediatric residency, same, 1968-71; rehab medicine residency, same, 1980-84; elected by Central Medical Society.

TERRELL, ROBERT E., Ocean Springs. Born Blytheville, AR, October 28, 1949; MD University of Oklahoma College of Medicine, Oklahoma City, OK, 1985; family practice residency, Same, 1985-88; elected by Singing River Medical Society.

MARIA V. VALDEZ, Holly Springs. Born Philippines, February 23, 1962; MD University of Philippines College of Medicine, Manila, Philippines, 1987; interned & pediatrics residency, State University of New York at Buffalo School of Medicine Medical Center, Brooklyn, NY 1990-93; clinical fellowship in pediatric endocrinology & metabolism. North Shore University Hospital, Mannasset, NY 1993-94; elected by North MS Medical Society.

WALKER, THOMAS A., Jackson. Born Elgin, IL, November 16, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1986; pediatrics residency, Tulane Affiliated Hospital, New Orleans, LA, and UMC, Medical Center, Jackson, MS, 1986-89; fellowship pediatric critical care, University of Alabama of Birmingham - Children's Hospital, Birmingham, LA, 1993-96; elected by Central Medical Society.

YOUNG, JERRY K., Tupelo. Born Union City, TN, November 30, 1959; MD University of Mississippi School of Medicine 1985; psychiatry residency, University of South Alabama Hospital & Clinic, Mobile, AL, 1985-89; elected by Northeast MS Medical Society.

YEAGER, DOUGLAS L., Jackson. Born Hinds Co., March 21, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family practice residency, University Medical Center, Jackson, MS, 1992-95; elected by Central Medical Society.

Deaths:

DOWDY, BILLY GENE, Greenville. Born November 9, 1938; MD University of Tennessee School of Medicine, Memphis, TN, 1964; interned one year, John Gaston Hospital, Memphis, TN; radiology residency, Methodist Hospital, Memphis, TN, 1967-70; died February 2, 1997 age 58.

SAFLEY, THOMAS J., Jackson. Born Copiah County, MS, August 11, 1910; MD Tulane School of Medicine, New Orleans, LA, 1940; interned two years, Charity Hospital, New Orleans, LA; surgery residency, Same, 1945-48; died March 7, 1997, Age 86.

SIEGRIST, HELEN D., Bay Saint Louis. Born Egypt, MS, October 28, 1911; MD University of Louisville School of Medicine, Louisville, KY, 1948; interned Blodgett Memorial Hospital, Grand Rapids, MI, 9/48 - 4/5/49 and Elizabeth Buxton Hospital, Newport News, VA, 7/49-1/50; surgery residency, Elizabeth Buxton Hospital, Newport News, VA, 1/50-6/50; anesthesiology residency, University Medical Center, Jackson, MS, 7/57-10/57; died January 1997, age 85.

SPELL, BOBBY GENE, Jackson .Born Georgetown, MS, May 14, 1930; MD University of Mississippi School of Medicine, Jackson, MS, 1959; interned one year, University of Texas Medical Center, Galveston, TX; orthopedic surgery residency, MS Baptist Hospital, Jackson, MS, 7/1/60 - 7/1/62 and Arkansas Medical Center, Little Rock, AR, 7/62-12/31/64; died January 22, 1997, age 66.



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Mary E. Pace., M.D., an internal medicine physician with the IMA Foundation in Tupelo, is staffing the newly opened Osteoporosis Evaluation Clinic and Internal Medicine Services at the North Mississippi Medical. Center Women's Hospital. IMA Foundation is a division of North Mississippi Health Services, the third largest rural hospital system in the United States. The clinic houses the only DEXA (dual-energy x-ray absorptiometry unit) in north Mississippi. Dr. Pace works closely with the patients who utilize the clinic and their family physician. She develops customized treatment plans that help patients gain a greater understanding of osteoporosis and actively participate in the management of their disease.

Richard L. Heyer, Jr., M.D. has been named Chairman of Medical Staff at North Mississippi Medical Center in Tupelo.

Jeffrey C. Houin M.D. of North Mississippi Medical Center in Tupelo has become Board Certified with the American Board of Dermatology and elected Fellow of American Academy of Dermatology.

William M. McKell, M.D. has left the practice of medicine to assume the position of Medico-Economic Clinical Advisor with the Singing River Hospital System in Pascagoula and Ocean Springs. Dr. McKell is a graduate of the University of Mississippi School of Medicine. Following an internship at Wilford Hall USAF Hospital in San Antonio, he returned to UMC where he completed an internal medicine residency and a gastroenterology fellowship.

David McAfee, M.D., an anesthesiologist who runs a pain management center in the Biloxi Outpatient Surgery and Endoscopy Center (BOSEC), announces the center is now offering an online look at their services and staff. The site is located at: http://www.msvirtual mall.com/bosec. The center has made attempts to seek out affiliations with some online state entities such as the Mississippi virtual Mall (www.msvirtualmall.com) and the Mississippi Medical Mall (www.msmedicalmall.com) in addition to our own site development. The Biloxi Outpatient Surgery & Endoscopy Center is located at 111 LaMeuse Street, Suite 104, in Biloxi, Mississippi. BOSEC is a privately owned, licensed and Accredited outpatient surgical center. Established in 1977, it was the first freestanding outpatient surgery center in Mississippi. It is designed to allow patients to have surgical or endoscopic procedures and to go to the privacy, comfort, and convenience of their own homes the same day. All physicians affi1liated with BOSEC are Board Certified and are members of the staff of local hospitals.

Christopher Ball, M.D. has been named Methodist Medical, in Jackson, Center's cheif of staff-elect for 1997. Dr. Ball, who joined Methodist Medical Center's Clinic for Women in 1985, received his Doctor of Medicine degree from the University of Mississippi's School of Medicine. He completed his internship and residency at the University of Alabama in Birmingham. He is a president of the Jackson OB-GYN Society.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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Neuroretinitis in Cat Scratch Disease Associated with Macular Star

Bryant McCrary, M.D., F.A.A.P
Walter Cockerham, M.D.
Patrick Pierce, M.D.

An 11-year-old white female presented to a local ophthalmologist with a history of unilateral blurred vision for 1 month and intermittent headaches. These symptoms followed a flu-like illness characterized by fever of 103'F for 2 days, headaches, nausea and myalgia. She was found to have papilledema and 20/60 vision in the left eye, magnetic resonance imaging scan was performed and was normal, and the child was subsequently referred to a retinologist. He found her vision to be 20/100 in the left eye and noted the macular star formation (Fig. 1). Because of a previous association in the ophthalmology literature between the macular star and cat-scratch disease, the retinologist referred her to our pediatric clinic for evaluation.

At the time of her visit she was afebrile and asymptomatic except for blurred vision of the left eye. She had acquired a new cat 4 months before her illness. The physical examination was normal with no adenopathy, skin lesions or external eye findings. We treated her for 10 days with trimethoprim-sulfamethoxazole and obtained serum *Bartonella henselae* titers from the Centers for Disease Control and Prevention in Atlanta. Serology was positive at 1:2048. At the last ophthalmology follow-up 6 weeks later, papilledema was clearing and vision improved to 20/60 in the left eye.

In 1916 Theodor Leber[1] described the clinical syndrome idiopathic stellate retinopathy, which was characterized by unilateral loss of vision, optic disc swelling, macular star formation and spontaneous resolution in 6 to 12 weeks otherwise healthy patients. Leber's neuroretinitis has been previously reported in association with cat-scratch disease.[2-4] The macular star is formed when lipid-rich exudate leaks from the capillaries within the optic head and extends into the subretinal space and macular region. Loss of visual function primarily results from changes in the optic nerve head and not the macula.[5]

This case represents further confirmation of the macular star as an ocular manifestation of cat-scratch disease. The rare clinical presentation of neuroretinitis as the sole expression of cat-scratch disease and the supporting *B. henselae* titers were thought to be worthy of reporting to other pediatricians.



Fig. 1: Macular Star Formation of Cat Scratch Disease

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Bryant McCrary, M.D., F.A.A. *recived his pediatric training at Arkansas Children's Hospital where he was Cheif Resident in 1980-81. He has practiced general pediatrics at Gulf Coast Pediatric Clinic since 1981 in Gulfport, Mississippi.*

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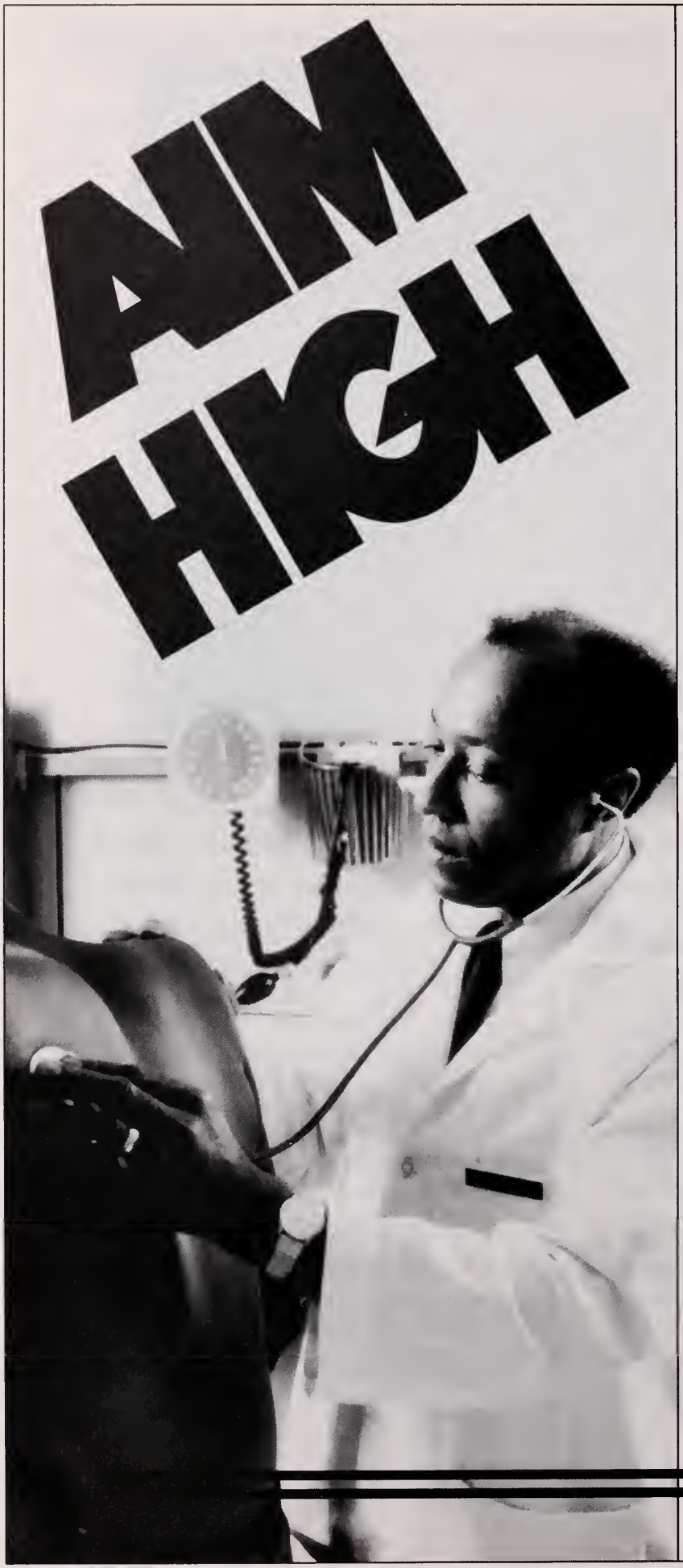
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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XVII

Selection and Preparation:
Edward F. Daly, III, M.D.
Nancy T. Kubiak, M.D.

Joe C. Files, M.D., *Editor*

Differential Findings: Rebecca Waterer, M.D.
Radiological Findings: Michael Merritt, M.D.
Pathological Findings: Charulochana Subramony, M.D.

CASE PRESENTATION

A 71 year old white female with a history of bipolar disorder was brought to UMC by her family for workup of abdominal distention. She had been in her usual state of health until six months prior to admission when she presented to an outside hospital with complaints of anorexia and a 40 lb weight loss over the preceding two months. At that time, she underwent a CT of the abdomen revealing only gallstones, which were subsequently removed. Over the next six months, she regained the 40 lbs and noted increasing abdominal distention. At presentation to UMC, she denied abdominal pain, pruritus, early satiety, fever, chills, jaundice, hematemesis, hematochezia, or melena. She had a cough productive of white sputum, but denied night sweats nor history of tuberculosis exposure.

Her past medical history was significant for bipolar disorder and hypertension. Her past surgical history included a hemorrhoidectomy, BTL, and an exploratory laparotomy with cholecystectomy. She denied alcohol use, smoking or illicit drug use. Her family history was significant for hypertension and a brother with "liver problems". Her medications on admission were ranitidine 150 mg b.i.d., spironolactone 25 mg daily, Thorazine, lithium, potassium chloride 20 mEq daily, and furosemide 20 mg b.i.d.

On physical examination, her vitals included a temperature of 99.5°, a pulse of 96, respiration of 20, and her blood pressure was 133/73. Generally, she was an elderly female in no acute distress, alert and oriented x 3. HEENT: TMs and oropharynx were unremarkable. Extraocular movements were intact. She had no bulbar conjunctival icterus. Her neck showed no elevated jugular pressure, bruits, thyromegaly, or adenopathy. On chest, she had bilateral scattered rhonchi and rales, no spider angiomas or jaundice noted. On cardiovascular, she had distant heart sounds, regular rhythm, no murmurs, gallops, nor rubs. Her abdomen was soft, nontender, but markedly distended with a fluid wave and shifting dullness. Bowel sounds were present. There was no hepatosplenomegaly by percussion, but a caput medusa was noted.

Her pelvic exam showed no masses that were felt and a normal uterine size. There were prominent external hemorrhoids noted, normal tone, and heme negative loose stool noted. On extremities, she has 2+ pitting edema bilaterally up to sacrum. On neurological exam, her cranial nerves II-XII were intact, motor was 5/5 in both upper extremities, but 3/5 in both lower extremities. Sensation was intact.

Her laboratory results included a hemoglobin of 11.9, hematocrit of 34.8, platelets of 237,000, an MCV of 85, an RDW of 15.3, and a WBC of 5.7. She had a Na of 145, K of 4.7, Cl of 106, CO2 of 26, a BUN of 7 with a creatinine of 1.2. Her AFP was 2.5 and her ferritin was 50. Her AST was 22, ALT was 28, GGT was 62, alk phos was 160, bilirubin was 0.57, TG was 36, and her iron was 78. Her HCV Ab was negative. She had a PT of 12.6, a PTT of 28.1, T Pro of 6.6, albumin of 2.5, LDH of 418, a CK of < 20. Her lipase was < 10, her amylase was < 30, and her lithium was < .2.

Examination of her peritoneal fluid showed a white count of 93 with 29 segs, 7 bands, 11 lymphs, 13 monos, 33 macrophages, and 8 mesothelial cells. Her red blood cell count was 11, her albumin was 0.8, her glucose was 87, and her LDH was 248. Her cultures, gram stain, AFB and cytology were all negative. A PPD skin test was negative with positive control. Her chest x- ray showed a mildly enlarged heart and uncoiling of the aorta. A KUB showed demineralized osseous structures and a nonspecific gas pattern. Her echocardiogram revealed normal left ventricular function. The abdominal ultrasound showed small nodular liver, patent portal vein and IVC, and a slightly enlarged spleen. CT of the abdomen revealed small bilateral pleural effusions. The liver had nodular contour, the spleen was slightly enlarged, and ascites were present. There were no ovarian abnormalities noted.

Dr. Merritt: The first study obtained on admission, a chest x-ray, demonstrates mild cardiomegaly and uncoiling of the aorta. No circumscribed infiltrates or pleural effusion is seen. Stranding density at the bases

was favored to represent pleural scarring related to prior inflammation. A DUB obtained at the same time shows many loops of air filled small bowel measuring 2.5-3.0cm in diameter making it mildly distended. No air fluid levels are seen, but the film is taken supine. The abdomen appears to be distended and the loops of small bowel are separated slightly, an appearance consistent with ascites.

Abdominal CT done 4 hours later has a scout view of the abdomen showing central displacement of multiple mildly dilated loops of small bowel, with inapparent liver and spleen edges. This appearance is also consistent with ascites. Cuts through the lower chest demonstrate mild cardiomegaly and bilateral pleural effusions, left greater than right. On the right side as you go down you see fluid density before you see liver. Subsequent images show a significant amount of free fluid in the abdomen and pelvis. The liver is small and has a slightly nodular border, an appearance the suggests cirrhosis. The density of the liver is normal, isodense with spleen. The gallbladder is absent, this is consistent with the patient's surgical history. Air is seen centrally over the porta hepatis. The central location of the air suggests biliary air, which can be associated with cholecystectomy is a sphincterotomy of bilienteric fistula was performed. The spleen is enlarged. A splenic index of 480 or less is considered normal; this index is 550. The kidneys are small bilaterally, but otherwise normal in appearance. The ovaries are normal in appearance as well.

So, ascites, a cirrhotic appearing liver, and splenomegaly led to an ultrasound evaluation of the portal vein to evaluate for portal hypertension. On ultrasound, the liver was again noted to be small but was of normal echogenicity and had no focal defects. Ascites is noted adjacent to the liver. Doppler studies performed on the portal vein showed a normal direction of flow.

Please discuss the differential diagnosis in this patient. What is the next best diagnostic test?

Dr. Waterer: When I first read this case, I realized that this is a very challenging case with a broad differential diagnosis. I have a lot of material to cover in a short time. This is a case of a 71 year old white female with a chief complaint of abdominal distention. Six months ago she had anorexia and a 40 lb. weight loss, which lead to a hospitalization and evaluation about which we don't know anything other than the fact that she had gallstones that were surgically removed. She subsequently regained the 40 lbs. and noted increase in abdominal distention. Her only other historical complaint was that of cough productive of white sputum. We do not know the chronicity of that cough. Pertinent negatives were that she did not have included abdominal pain, pruritus, early satiety, fever, melena, jaundice, hematemesis, hematochezia, chills, or TB exposure. Her past medical history was positive for bipolar disorder and she also has had hypertension. Her past surgical history included a hemorrhoidectomy, bilateral tubal ligation which becomes important a little bit later, exploratory lap with cholecystectomy. Social: She has no history of alcohol use, smoking, or illicit drug use. Her family history is significant for hypertension and a brother with liver problems. That is interesting and we will revisit that shortly. Her medicines included ranitidine 150mg b.i.d., which we don't really know why she's on but that is probably fairly common in the community as a whole. She was also on spironolactone 25mg and we assume that her spironolactone, potassium supplement, and Lasix were added in relation to the treatment of her ascites. She was also on Thorazine and lithium, but we don't know the doses nor how long she's been on those medicines.

Pertinent physical findings: The HEENT exam was normal. On the neck exam, there was no evidence of elevated jugular venous distention. She had some remarkable lung findings including bilateral scattered rhonchi and rales, and as Dr. Merritt showed us, with the exception of some mild cardiomegaly, surprisingly no radiographic evidence of lung disease. Cardiovascular exam was remarkable only for distant heart sounds. There was no murmur noted. Abdominal exam was clearly the most remarkable physical finding with fluid wave, shifting dullness, but no obvious hepatosplenomegaly which would be hard to ascertain in a patient with that much ascites. The pelvic examination was within normal limits, which is extremely important in an evaluation of patients of this nature. She did have pitting edema all the way to her sacrum and she had on neurologic exam, motor strength uniformly decreased in her lower extremities.

The laboratory abnormalities, with the normal values at UMC, included normocytic anemia. Her white count was normal. Her platelet count was normal. She had modest elevation of her liver enzymes. An albumin of 2.5 is extremely troubling. Peritoneal fluid analysis was basically unremarkable. Some additional information that was provided to us that can help in our differential as we start trying to eliminate and include possibilities in this patient include: PPD was negative with a positive control, so she is not anergic. KUB showed some demineralization and that is important as we get further into the differential, but remember this is a 71 year old lady who does not appear to be on any estrogen replace-

ment, so that is what I would expect. Her echocardiogram showed a normal left ventricular function. Abdominal ultrasound, as Dr. Merritt has already alluded to, basically showed a small liver, splenomegaly, and importantly her ovaries were normal. The portal vein and inferior vena cava were able to be visualized by ultrasound and reported as patent. Other important normal laboratory data included the BUN and creatinine being normal, iron studies being normal, alpha-feta protein being normal, and hepatitis B surface antigen and C antibody negative.

How do we evaluate ascites? For many, many years the absolute protein content of ascitic fluid has been used to differentiate transudates, which have low fluid protein contents from exudates, which have the higher fluid protein content. Bruce Runyon, who is a gastroenterologist at the University of Iowa, in the latter part of the 1980s and early 1990s described the serum ascites-albumin gradient as a means of predicting ascites as a consequence of portal hypertension as opposed to ascites in the absence of portal hypertension, such as in the cases of peritoneal carcinomatosis and tuberculous peritonitis. He claims that a high serum ascites albumin gradient correlates with the presence of portal hypertension 97% of the time, as opposed to the old exudate/transudate concept prediction of only about 55%. He published that data in the Annals of Internal Medicine in August, 1992.[1] Since the data provided to us allows for the calculation of the serum ascites gradient, that value is simply the ascitic fluid albumin subtracted from the serum albumin. Runyan classifies high gradients of values > 1.1. Our patient had a gradient of 1.7gm/dl.

TABLE A[2]

Transudative Ascites
- Cirrhosis
- Chronic Hepatic Congestion
  - •Budd-Chiari Syndrome
  - •Constrictive pericarditis
  - •Right heart failure
- Nephrotic Syndrome
- Meigs Syndrome

Exudative Ascites
- Tuberculous peritonitis
- Pancreatitis
- Ruptured viscus (including bile peritonitis)
- Tumors

Table B[3]

High Serum-Ascites Albumin Gradient

- Cirrhosis	- Alcoholic hepatitis
- Fulminant hepatic failure	- Cardiac failure
- Massive liver metastasis	- Budd-Chiari syndrome
- Portal-vein thrombosis	- Veno-occlusive disease
- "Mixed ascites"	- Myxedema

Low Serum-Ascites Albumin Gradient

- Peritoneal carcinomatosis	- Biliary ascites
- Peritoneal tuberculosis	- Nephrotic syndrome
- Pancreatic Ascites	- Serositis
- Bowel obstruction or infarction	

Generally when we think of ascites we have a knee-jerk response that this is certainly cirrhosis. There are several other causes of ascites. Fulminant hepatic failure can also be the cause, and this lady had such modest elevations of her transaminases that this is surely not her diagnosis. Massive liver metastasis can do it, but we have radiographic imaging that makes that extremely unlikely. Portal vein thrombosis, which we are going to talk a little bit more about shortly, is also a consideration. Fatty liver of pregnancy I'm sure does not apply to this patient. Alcoholic hepatitis can give a high serum ascites albumin gradient as can cardiac failure, which she did not appear to be in by physical exam at the time of evaluation. The Budd-Chiari syndrome and veno-occlusive disease are causes, both of which I will discuss later. Relative to myxedema, this lady didn't have any evidence of profound hypothyroidism. That basically leaves us with cirrhosis. The high serum ascites albumin gradient suggests that we have portal hypertension at least 97% of the time, if you believe Runyan. Before going on to the liver causes of portal hypertension, let's at least spend a little time discussing portal hypertension in the absence of liver diseases. Splenomegaly not due to liver disease, as occurs in cases of polycythemia vera, myelofibrosis, and Gaucher's disease, does occur. Arteriovenous fistulas can be a consequence of abdominal trauma, liver biopsy, carcinomas, either intra- or extrahepatic or rupture of an arterial aneurysm such as a splenic aneurysm. It should be noted at this point that our patient was not noted to have either an abdominal bruit or a thrill, which is often present in cases of AV fistulas. Diseases of the cardiovascular system which can lead to portal hypertension include the portal vein thrombosis, which may develop following abdominal trauma or intra-abdominal sepsis, or in association with cirrhosis or hepatocellular carcinoma. The

majority of the cases, however, are idiopathic. It's primarily a disease of children, but can develop in adults. Our patient was reported to have a patent portal vein by ultrasound, which I'm told is highly sensitive and specific in proper hands, which I know we have. Splenic vein thrombosis may be secondary to pancreatitis, abdominal trauma, or a locally invasive tumor. In these disease, the liver is normal. By ultrasound and CT our patient's liver does not appear to be normal. Hepatic vein thrombosis, or the Budd-Chiari syndrome, may follow abdominal trauma or the use of oral contraceptive pills. It may occur in patients with P-vera, paroxysmal nocturnal hemoglobinuria, or any other condition which may lead to a hypercoagulable state. They can have either an acute, subacute, or chronic illness. Abdominal pain and ascites are the major features. Mild elevations of serum transaminases may be present, but the liver is usually large and tender. Veno-occlusive disease, which is actually non-thrombotic, can also occur in patients who ingest certain plant containing alkaloids, which these are not usual food products, but poisonous plants. This has also been reported in patients who have had chemotherapeutic agents, particularly the alkylating agents. These pathologic findings are frequently seen in patients with alcoholic hepatitis and cirrhosis, and is felt to be due to the toxic effect on the endothelium of the affected vessels. Thrombi, tumor, or membrane in the inferior vena cava can cause portal hypertension. These patients usually have peripheral edema and stasis dermatitis. The membrane type is often seen in South Africa and the Orient. Our patient's previous history of weight loss is bothersome for a possible malignant etiology, but we have very good radiographic evidence by CT and ultrasound that there is not at least a solid tumor present. The IVC obviously again was reported as being patent on ultrasound.[4]

On to liver disease as a cause of portal hypertension, cirrhosis is by far the most common cause. Portal hypertension due to non-cirrhotic portal fibrosis is felt to possibly be an etiology in schistosomiasis, but that is still debated as best I can tell. Idiopathic portal hypertension, or Banti's syndrome, includes portal hypertension, no cirrhosis, and a patent portal vein. This is a slowly progressive disease with a normal liver biopsy very early followed by the development of periportal fibrosis. The end result is a small fibrotic liver. That is an interesting concept, particularly in a 71 year old lady who, as best we could tell, did not have any significant liver disease for the majority of her life. I would certainly put that on my differential diagnosis.

Congenital hepatic fibrosis is also portal hypertension without cirrhosis and may be seen in cystic liver disease, which is Caroli's disease (intrahepatic ductal ectasia). This is frequently associated with polycystic renal disease. Pathologically, there is marked hyperplasia of the bile ducts and stellate fibrosis. Sarcoidosis is a rare cause of portal hypertension and hepatic fibrosis. As we mentioned, alcoholic hepatitis and partial nodular transformation are also listed.

There are broad categories of the etiologies of cirrhosis. When you are talking about cirrhosis, you can approach it from really three different possible ways. One of them would be from a histological standpoint: macronodular vs. micronodular; and from a morphologic standpoint, if you wish, but being a clinician I tend to like the etiologic approach to differential diagnosis. Let's start with congenital and genetic causes: starting with Wilson's disease, it is autosomal recessive. We talked about the brother with "liver problems". We don't know anything else about the brother. We don't know whether he was a drinker, but family history is probably a useful hint. It is a metabolic defect, which leads to the gradual and progressive accumulation of copper in the liver. It is due to a partial or complete deficiency of ceruloplasmin, which is essential for normal copper metabolism.

Cirrhosis may be evident as early as age 6, but may be delayed for decades. Neurologic manifestations are common due to copper accumulation in the brain, particularly in the basal ganglia. The most common neurologic manifestation of Wilson's disease are dysarthria and loss of coordination of voluntary motor movements. Ninety-five percent of patients have Kayser-Fleischer rings which are the copper deposits in desciment's membrane. Commonly, these patients also have bone diseases such as osteoporosis, osteomalacia, and reduction of joint spaces in the limbs and spine. These patients can develop a renal tubular malfunction which can lead to hypercalciuria and alkaline urine. In our patient, with what appears to be cirrhosis, lower extremity weakness, osteoporosis, and a family history of liver problems, I would strongly consider Wilson's disease as a possible etiology, even though she does not appear to have Kayser-Fleischer rings. Five percent of the people who have Wilson's disease may not have them and many times they are evident only by slit lamp examination.

Idiopathic hemochromatosis is also autosomal recessive. It is a disorder of progressive iron accumulation which can lead to cirrhosis. It is relatively common, affecting 1 in 400-1,000 persons. Symptoms begin in the 50s in men and in the 60s in women. The most common presenting symptom is abdominal pain. Bronzing of the

skin is seen in 80% of the patients. Elevated serum iron levels, total iron binding capacity, and ferritin are seen. The gold standard for the diagnosis of hemachromatosis is the liver biopsy for quantitative iron studies. Since our patient was reported to have normal iron studies, hemachromatosis is an unlikely diagnosis. Abetalipoproteinemia is a rare autosomal recessive disorder in which there is a defect in apolipoprotein B 100 synthesis or secretion resulting in very low total cholesterol levels of around 50-80. We weren't given a cholesterol level but we were given a triglyceride level of 36. These people also have very low triglycerides, usually < 30. Its clinical manifestations begin at birth and include fat malabsorption, acanthocytosis, retinitis pigmentosa, and neuromuscular dysfunction resembling Friedrich's ataxia. Aside from our patient's low triglyceride level, this etiology would be unlikely in the absence of retinitis pigmentosa and ataxia.

Cystic fibrosis is worth talking about. It is autosomal recessive, affects 1 in 2000 whites, 1 in 17,000 blacks, and 1 in 90,000 full blooded Asians. Pathophysiologically, there is impaired chloride permeability preventing normal chloride absorption. Primarily a disease of childhood, the most susceptible organs are the sweat glands and the respiratory epithelium. It also affects the GI tract in a variety of ways ranging from meconium ileus at birth to progressive pancreatic exocrine insufficiency, rectal prolapse, and focal biliary cirrhosis. About 10-30% of CF patients will have focal biliary cirrhosis at the time of autopsy. A very small number of patients will develop adult onset cystic fibrosis. In our patient with a family history of liver disease, cough with white sputum production, rales, and rhonchi on physical exam, it is worth consideration. However, I would expect to see the radiographic evidence of hyperinflation, increased pulmonary markings, and possibly even cystic bronchiectatic changes. I mentioned earlier about her tubal ligation. We were not provided an obstetrical history and many times people who wind up developing adult onset cystic fibrosis are infertile. The fact that she has had a bilateral tubal ligation implies that she has at some point in her life been fertile. Based on these observations, I would presume that CF is less likely in this patient.

Galactosemia is an autosomal recessive deficiency of lactose 1 phosphate uridyl transferase activity with a subsequent inability to breakdown galactose. The symptoms begin shortly after birth and include diarrhea and vomiting, jaundice, hepatomegaly, and elevation of the liver enzymes. If undiagnosed, it leads to cataracts, developmental delay, profound mental retardation, and eventually cirrhosis. That would be extremely unusual in this age lady. The glycogen storage disease Cori type III is also known as type IV glycogen storage disease, or branching enzyme deficiency, or amylopectinosis, or Andersen's disease. It is autosomal recessive. It is a deficiency of the branching enzyme which leads to accumulation of abnormally structured glycogen with unbranched outer chains. This is basically a children's disease, progresses to cirrhosis and death usually occurs by age 5. Hereditary tyrosinemia is autosomal recessive, has onset in infancy characterized by cirrhosis, renotubual syndrome and hypophosphatemic rickets. Niemann-Pick disease is autosomal recessive. It is a sphingomyelin lipidosis and there are four types, all of which are fatal in childhood or adolescence, except type B, in which there is no cerebral involvement. Splenomegaly occurs in the first four years of life, then hepatomegaly follows. In type B, neurologic signs are absent. The Niemann-Pick cell is present in the reticuloendothelial system and despite surviving childhood, death usually occurs in early adulthood and I would not expect a patient to live into her 70s.

Gaucher's disease is a relatively common autosomal recessive disorder, resulting from progressive accumulation of glucocerebroside within phagocytic cells of the monocyte-macrophage system involving principally the liver, spleen, bone marrow, and lymph nodes. Type I, a chronic non-neuropathic or adult form, may appear at any age. It causes splenomegaly, liver enlargement and fibrosis, and bone lesions. Portal hypertension may develop.

There is no proliferation of the bile ducts and liver failure is quite rare. One of the earliest radiographic signs of bone involvement is the Erlenmeyer flask deformity of the distal femur. Frequently, these people will not complain of bone pain, as this lady did not. We don't have x-rays of that area. Gaucher cells, a distinctive morphologic large phagocyte, are present in virtually all organs. They may be surrounding small blood vessels or in sheets infiltrating their parenchyma. It has been seen in whites, blacks, and Asians, but more than half of all cases are seen in Asiatic Jews. Clinical symptoms in the adult form may appear in any age, from the first year of life to the ninth decade. Slowly progressive splenomegaly is the usual pattern, and in a few severe cases, liver failure and portal hypertension may occur. Bone marrow may demonstrate Gaucher cells. The diagnosis is established by assaying the activity of glucosyl ceramide beta-D glucosidase in the leukocytes or cultured fibroblasts. Because of our patient's family history of liver disease, advancing age at the time or presentation, and presence of splenomegaly, Gaucher's disease, chronic neuropathic

type, is certainly a reasonable diagnosis.

Mucopolysaccharidosis: There are a variety of these diseases, including Hurler's disease, Hunter's syndrome, and Sanfilippo disease, that are almost uniformly detected during childhood due to specific manifestations such as skeletal abnormalities particularly facial abnormalities, deafness, varying degrees of mental retardation, and corneal clouding, which is extremely common in the mucopolysaccharidoses; none of which seem to be present in our patient.

Cystinosis is an autosomal recessive condition in which there is accumulation of cystine in the lysosomes of many different body tissues, including the liver. However, the most frequent clinical manifestations are due to early tubular renal defects and progressive renal disease and subsequent renal failure. Wolman's disease, due to acid lipase deficiency, is autosomal recessive, and causes xanthomatous changes occurring in the liver and other organs shortly after birth. Children rarely survive their infancy. Zellweger's syndrome is autosomal recessive, a paroxysmal disorder, leading to storage of very long chain fatty acids and biliary dysgenesis, and again death occurs in childhood. Neonatal adrenal leukodystrophy is a genetic disorder which results in accumulation of very long chain fatty acids in the serum and in the cells.

Neurologic manifestations are the predominating clinical findings in the beginning mid to late childhood and can be quite profound, such as bilateral hemiaplasia with pseudobulbar palsies. The hereditary hemorrhagic telangiectasia is also known as Osler-Weber-Rendu disease. It's autosomal dominant. It's a disease where telangiectasias are found throughout the body and they have tendencies to bleed. The diagnosis is usually made by identifying on the skin or mucus membranes brown to red macules that blanch under pressure, epistaxis, and either chronic or acute GI bleeding. Our patient was not reported to have any evidence of telangiectasias on mucus membrane exam. Alpha-I antitrypsin deficiency ia an autosomal codominant disorder. Alpha-I antitrypsin is a glycoprotein produced by the hepatocytes and the mononuclear phagocytes, which functions in the body to inhibit the proteolytic enzymes (elastase, collagenase, trypsin, and chymotrypsin). Deficiency of this enzyme leads to tissue destruction. There are thirty electrophoretic variants of the enzyme which delineate the specific phenotype. The lung is particularly susceptible to decreased levels of Alpha-I antitrypsin. Sixty to seventy percent of patients with the ZZ phenotype will develop severe emphysema. Those who do develop emphysema, usually have the onset of their dyspnea in their 50s if they are a nonsmoker and in their 40s if they are a smoker. Alpha-I antitrypsin deficiency can lead to cirrhosis and an increased incidence of hepatocellular carcinoma, as well. Our patient did not complain of any breathlessness, but did have a cough with white sputum production. Auscultation certainly suggested at least partial airway obstruction, but the lung fields were apparently unremarkable by radiographs. Since as many as 10-20% of the ZZ phenotype patients may have little or no detectable emphysema, Alpha-I antitrypsin deficiency is a very likely diagnosis in our patient and the diagnosis is made by determining the serum level of the enzyme. If it is < 35% of the expected value, that is considered diagnostic of the deficiency and electrophoretic analysis should be used to determine the phenotype.[5]

Drugs and chemicals are something that we should always think about, particularly when we are looking at etiologies. These drugs and chemicals have been associated with causing cirrhosis. Cinchophen is an analgesic, antipruritic, and uricosuric agent which was previously used to treat gout and acute rheumatic fever. I don't think that is available any more. Oxyphenisatin is a cathartic which was withdrawn from the market in the mid-1970s due to significant incidence of hepatic injury. Perhexiline maleate is an antianginal preparation which is similar to the calcium channel blockers and is used only in England. As you know, the RDA for Vitamin A is about 1,000mcg/day and Vitamin A cirrhosis tends to occur in those individuals who take about 15 times that. Dimethylnitrosamine is a chemical that is used in industry as a solvent. It is worth mentioning, on the subject of drugs, that oneof the drugs this lady had previously been prescribed is associated with hepatic toxicity, that being Thorazine. Hepatotoxicity does occur in the form of obstructive jaundice, but its overall incidence is quite low. It is felt to represent a hypersensitivity reaction and usually occurs between the second and fourth week of therapy and is usually promptly reversible on discontinuing the drug. There have been rare cases reported of chronic jaundice, but there is no good evidence that leads in and of itself tocirrhosis.[6] There is, of course, alcohol related cirrhosis. That's probably what we are most familiar with, and clearly not why we are here today. Our patient was not reported to be a drinker.

Cirrhosis following infections; Hepatitis B and C and D: We did have evidence of a negative hepatitis C antibody in this lady, and the surface antigen for hepatitis B was negative. She did not have any symptoms that would go along with an acute viral hepatitis and congenital syphilis is extremely unlikely. She has not had any bypass surgery, as far as we know. On the subject, we don't know anything about exactly what surgery was done

on her. I don't know if she had an open cholecystectomy or a laparoscopic one. Primary biliary cirrhosis is a chronic progressive cholecystatic syndrome of unknown etiology that affects predominantly women in their sixth and seventh decades. Familial occurrences have rarely been reported, however. The most common presenting scenario is insidious onset of pruritus and fatigue. Jaundice is present about 25% of the time. Physical findings include hepatomegaly, splenomegaly, hyperpigmentation, and stigmata of chronic liver disease. The triad of elevated serum alkaline phosphatase, detectable levels of antimitochondrial antibody, and the elevated serum IgM is of considerable value in the diagnosis of PBC. Liver biopsy with special stains for copper is critical in diagnosis. The only mild increase in the serum alkaline phosphatase, absence of pruritus, fatigue, or jaundice would make my clinical suspicion of PBC in our patient fairly low. Chronic biliary obstruction: When obstruction lasts more than a minimum of four months and usually up to a year, it can lead to cirrhosis. We know that this lady has had a cholecystectomy, but we know nothing about what her liver looked like at the time of surgery. We would suspect that she would have had a significant amount of morbidity if she had obstruction or at least common duct obstruction for a four month period of time.

Heart failure and outflow obstruction can lead to cirrhosis. This lady had no prior history of congestive heart failure and I've already been told she had a normal left ventricular function. The chronic hepatic vein obstruction, we have already discussed. Constrictive pericarditis is a possibility, but there is almost always at least a mild degree of shortness of breath associated with constrictive pericarditis and easy fatigability is common. They may have as cites and lower extremity edema and possibly even pleural effusions, which our patient did have. But the key to diagnosis when you are considering constrictive pericarditis on physical exam, is to recognize elevated jugular pressure. Our patient was noted to have flat neck veins. Sarcoidosis is actually a rare cause of cirrhosis, but we always include it as a possibility.

Idiopathic or cryptogenic cirrhosis: Any cirrhosis for which the etiology is unknown is considered to be cryptogenic or idiopathic cirrhosis. In order to diagnose that, you have to rule out all the other diseases, as I have already explained. The liver contains little or no necrosis or inflammation and no diagnostic pathological lesions on biopsy. Histochemical stains for iron and Alpha-I antitrypsin are negative. The viral markers are negative for both C and B hepatitis. Antimitochondrial antibodies are negative and ceruloplasmin is normal.

After having said all that, where do we go? At this point, my differential diagnosis would include Banti's syndrome, which is the idiopathic portal hypertension, Wilson's disease, Gaucher's disease, Alpha-I antitrypsin deficiency, or cryptogenic cirrhosis. Much less likely is primary biliary cirrhosis or adult onset CF. The test I would like to get would be a liver biopsy because there are a lot of things that a liver biopsy would show to better delineate the diagnosis. We could check antimitochondrial antibodies, but we could not rule out things like Wilson's disease or Alpha-I antitrypsin. We could also check a serum Alpha-I antitrypsin deficiency, but there are other things on histochemical stains that we need from the actual biopsy.

The correct procedure was a liver biopsy. Dr. Subramony will discuss the findings from that biopsy.

Dr. Subramony: The liver biopsy is in multiple fragments. The normal architecture of the liver is altered by fibrous septa dividing the liver into nodules. There is a moderate lymphocytic infiltrate in the septa. Mild piecemeal necrosis is noted. The hepatocytes in the nodule are arranged in liver cell cords that are 2-3 layers in thickness. The hepatocytes at the edge of the nodule contain small hyaline eosinophilic globules that are PAS positive and diastase resistant. By using the immunoperoxidase technique, these globules are positive for alpha-a antitrypsin.

Diagnosis: chronic active hepatitis with cirrhosis of liver secondary to alpha-1 antitrypsin deficiency.

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*Dr. Files is Professor of Medicine and Associate Chairman for Clinical Affairs, Department of Medicine. **Dr. Waterer** is Assistant Professor of Medicine; **Dr. Merritt** is a Resident in the Department of Radiology and **Dr. Subramony** is an Associate Professor of Pathology. **Drs. Kubiak and Daly** were Chief Medicine Residents in the Department of Medicine in 1995-1996 at the University Medical Center.*



H. Vann Craig, M.D.

The President's Page

The Challenge

This year I would like to challenge each member of MSMA to become involved.

Involved with your local community. Participate in a local project and take credit for what you do.

Involved with your local state legislator. Ask them to lunch or have a small fund raiser for them.

Involved with your component Medical Society and Alliance. Their projects are worthy of our support.

Involved with your Hospital Medical Staff. While this competes with the component society for time and energy, we need to attend and participate lest we become employees rather than partners.

Involved with MSMA. Our Association does a good job of delivering services to members and is well worth its dues as value received.

And, involved with AMA. The AMA protects the legacy of Medicine as an ethical and highly skilled profession.

This involvement will not come without cost, cost in time, money, and energy. The reward of a job well done for your patients and others returns the cost many times over.

Involvement and commitment to organized medicine should be basic - like Ham and Eggs. The chicken was involved. The pig was committed!

Perhaps if you become involved, you may also wish to become committed.

Vann



L to R: Billy Brunt, Frances Stewart, John Pearson

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 5
MAY 1997

Calling All Camera Buffs-
MSMA Sponsors Photography Competition

Let's talk about us for a while, the *MSMA JOURNAL* that is. I don't know about you all, but I sure do miss the beautiful, medically inspired art work we used to have on our cover each month.

Since January 1997, our cover page has put me in mind of a Volkswagon Beetle, functional and efficient but at the same time, quite boring and unattractive, and hopefully soon to be as obsolete.

While sorting out mail a couple of months ago I failed to recognize the *JOURNAL* and absently tossed it in the trash thinking that it was just another one of those unsolicited "throw away" journals that everyone gets but absolutely no one reads.

Something had to be done. We hit upon the idea of a photography competition among our membership with the top entries appearing on the *MSMA JOURNAL* cover each month in 1998.

Last week the Mississippi Academy of Family Physicians held their Spring Fling Meeting an a Caribbean Cruise Ship. Clever, eh?

Yours truly shot about seven rolls of film. The young man at the photography desk at WalMart intuitively noted "You must have had a really good trip this time, huh, 'Doc'?"

He's right you know. I wanted to capture those people and places to remember forever. I have pictures of a smiling and soaked Stanley and Beth Hartness forging their way up Dunn's River Falls in Ocho Rios, Jamaica... of Joe Johnston flying the world's best kite off the side of the cruise ship MS Niew Amsterdam as we departed Cozumel . . . of Judy and Greg Gearhart forlornly standing on the beach at Grand Cayman when they missed the glass bottom boat excursion by a mere thirty seconds . . .of George Abraham modeling a collapsible sombrero on the cliffs of the Mayan ruins at Tulum . . . and of blissful seascapes and sunsets that are most unforgettable.

It wasn't all pretty. There were parts of Jamaica that reminded me of the Mississippi Delta of the sixties - cardboard houses, mountains of trash, and five wrecked cars in every yard - you get the picture. But a photograph doesn't have to be aesthetically pleasing to make a profound statement.

Remember, there truly is no place like home. Nothing we saw on the trip could surpass the passionate nostalgia that wells up in you at the sight of blooming dogwoods, red buds and flowering wild pears on the roadsides or masses of daffodils in a well-kept yard.

Faraway places may beckon but consider strongly the often overlooked grandeur of Mississippi when you select your pictures . . . our historic pilgrimage homes, the Natchez Trace, the Gulf Coast and Barrier Islands, the Mississippi River and thousands of lakes and streams in this "Father of Waters", historic Civil War battlefields, but don't neglect that single perfect rose in your own garden.

Turn your thoughts loose. Your photograph may have a theme or illustrate an idea, but it might simply be a vision of something lovely.

Your entries should be approximately 5 x 7 color prints with a brief description of yourself and your subject attached. Vertical format prints are preferred but horizontal photos can be modified to fit.

The entries will be judged on merits of quality, composition, originality and appropriateness to the *JOURNAL MSMA*. Also, you may submit several entries. The top twelve winning photographs will appear on the cover of the *JOURNAL MSMA* (one per month) and you and your subject matter will be recognized in that month's issue.

Mail your pictures to : Karen Evers, Managing Editor, *JOURNAL MSMA,* P. O. Box 5229, Jackson, MS 39296.

-Dwalia South, M.D., Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



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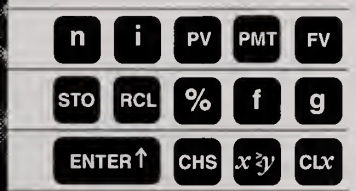
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California Proposition 215 and Arizona Health Proposition 200 Challenged

Dear Medical Leader:

On December 30, 1996, Barry R. McCaffrey, Director of the Office of National Drug Control Policy, Attorney General Janet Reno, and Donna E. Shalala, Secretary of the Department of Health and Human Services (HHS), announced the Administration's position regarding the recent passage of California Proposition 215 and Arizona Proposition 200. Among other things, they stated that the Department of Justice and HHS would follow up with a letter to national, state, and local medical organizations such as yours with respect to the Administration's position.

We are concerned that several misperceptions have developed concerning the federal government's response to the two Propositions. Before their enactment, nothing in federal law prevented a physician, in the context of a legitimate physician-patient relationship, from merely discussing with a patient the risks and alleged benefits of the use of marijuana to relieve pain or alleviate symptoms. This continues to be true.

The federal government recognizes that patients look to their physicians as their primary source of knowledge about a wide variety of potential health hazards and treatments. Thus, physicians are encouraged to talk with patients about their concerns and answer inquiries about any procedure, treatment, substance, or device that may affect a patient's health. Physicians are also encouraged to share their knowledge and their professional expertise regarding the risks, benefits, and legality of any potential medical treatment or modality. No "gag rule" stops physicians from engaging in these discussions.

Such discussions, however, have their limits. Physicians may not intentionally provide their patients with oral or written statements in order to enable them to obtain controlled substances in violation of federal law. Physicians who do so risk revocation of their DEA prescription authority, criminal prosecution, and exclusion from participation in the Medicare and Medicaid programs.

Federal law establishes specific criteria that every potential medication must meet before it can be sold to the public or prescribed by doctors. For decades, this process of federal drug approval has protected the American public from dangerous drugs and ineffective treatments, and has helped provide the public with a medical care system that is the envy of the world. This process must be preserved. What is, and what is not, a drug with an accepted medical use should continue to be determined through rigorous scientific testing.

To date, the scientific testing of marijuana has not demonstrated that marijuana is a safe and effective drug with an accepted medical use. We remain concerned that the weight of current scientific evidence shows that marijuana significantly harms the central nervous, cardiovascular, respiratory and immune systems, and can limit memory, perception, judgment, and the ability to drive a motor vehicle. In addition, marijuana smoke contains over 400 compounds, some of which are carcinogens and may be addictive.

The federal government is undertaking additional steps to analyze carefully the state of all available scientific knowledge about the risks and alleged benefits of marijuana for medicinal purposes. In January, the Office of National Drug Control Policy committed nearly $1 million to fund a comprehensive review by the Institute of Medicine of the National Academy of Sciences of the existing clinical, medical, and scientific knowledge of the health effects and potential medical use of smoked marijuana. Moreover, on February 19 and 20, 1997, the National Institutes of Health held a two-day workshop at which non-government experts in fields such as cancer treatment, infectious diseases, neurology, and ophthalmology reviewed existing research about marijuana, assessed what is known about its possible therapeutic potential, and discussed the factors to be taken into account in undertaking clinical research of marijuana. If and when there is adequate scientific evidence to support a reclassification of marijuana under the Controlled Substances Act, rulemaking proceedings could be used to change marijuana's current classification as a Schedule I controlled substance. However, unless and until that occurs, current federal law remains in effect.

Sincerely yours,

Jo Ivy Bouford, M.D.
Acting Assistant Secretary for Health
Department of Health and Human Services

What Happens When Physicians Get Together?

What happens when physicians get together?

There was a time when we would talk collegially about medical issues, new developments in our fields, complicated cases and how we dealt with them.

Now, it seems, we talk mostly about the business of medicine — managed care contracts and corporate mergers, risk sharing and entrepreneurship.

All of us are struggling to practice good medicine in a system that makes it increasingly difficult to do so. A system that, day by day, becomes less concerned with patients and more focused on the bottom line.

We've all seen enough to know what happens when corporate medicine moves in:

•Patients are shifted from one corporate entity to another at the drop of a dollar. The doctor-patient relationship is broken and continuity of care is lost.

•Patient care is micromanaged by insurers rather than physicians. We have fewer and fewer choices about the care our patients receive and where they can receive it.

•Growing numbers of our patients are underinsured or uninsured (currently 41 million Americans).

•Perhaps the most ominous of all: We as physicians are increasingly being put "at risk". Our income depends on our ability to rein in patient care, limit access, and increase corporate profits. In fact, it's *patients* who we put at risk in such a system — an insupportable violation of professional ethics.

We don't have to sit back and let this happen. We can speak out through our medical societies and support universal coverage. We must lead the fight for national health insurance. The longer we wait to take a stand for national health insurance, the weaker we become. Soon we will lose all control of our profession and become pawns in the managed care corporate complex. Wouldn't it be wonderful to go to a medical meeting and talk about medicines again!

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The Medicare-to-Private Payment Gap: Is Medicare the "High" Payer?

Access to health care services for beneficiaries in the Medicare program is dependent upon the adequacy of Medicare fees. A standard payment-based access indicator for physician services is the national average ratio of Medicare to private sector physician fees. Estimates of the national average gap between Medicare and private rates have ranged from 59% to 76% for the 1990-1994 period. The Physician Payment Review Commission (PPRC) estimates that Medicare paid 70% of what the average private insurer paid in 1995 (PPRC 1996).[1] In counterpoint to these studies are reports of Medicare being the high payer in certain instances.

Given variation in market competition, payments and service utilization across payers and regions, local area measures of the gap between Medicare and private sector fees may be more meaningful than national average benchmarks of the payment gap. Staff of the American Medical Association (AMA) Center for Health Policy Research have estimated local (metropolitan) area differentials between Medicare and private sector physician payments (Gillis and Wozniak 1996).

This report summarizes the full study. Across local areas, the Medicare/private sector price ratio for all physician services ranged from 0.44 to 0.84. Medicare payments were found to be lower than the private sector price in 92% of cases. Therefore, instances in which Medicare pays more than private payers appear to be isolated occurrences or based on questionable data.

I. AMA Research

A preliminary analysis considered a small group of surgical and medical procedures at the Medicare locality level. These procedures account for approximately 25% of surgical and medical expenditures. For this limited number of services, Medicare paid, on average, 69% of the private sector payment. The first and third quartile payment ratios were 55% and 74%, respectively. Of the 1,567 procedure/locality combinations with adequate data, the mean private payment was statistically significantly higher than the Medicare payment 97% of the time.

A more detailed examination of local area differentials between Medicare and private sector physician payments was then performed on a dataset with over 19,000 observations with various CPT-code/MSA combinations. (See appendix for details.) Overall, the Medicare payment was found to be statistically significantly lower than the private sector price in 92% of the cases analyzed. In only 3% of the cases was the Medicare payment statistically significantly higher than the private sector price. No significant difference between Medicare and private sector fees was found in the remaining 5% of cases.

Of the CPT-code/MSA combinations examined, there are only 13 services or procedures for which Medicare pays more than the private sector in 5% or more of the MSAs. Some of these, however, are not major Medicare services. By the sub-categories analyzed, these CPT codes are *E & M services:* 99245, office consultation; 99222, initial hospital care; 99241, office consultation; 99242, office consultation; and 99255, initial inpatient consult, *medical services and procedures:* 95117, immunotherapy injections; 95115, immunotherapy, one injection; 92004, eye exam, new patient; 95004, allergy skin tests; and 92567, tympanometry; *surgical procedures:* 17101, destruction of second lesion; 69210, remove impacted ear wax; 54150, and circumcision.[2]

The share of cases in which the private payment is statistically significantly greater than the Medicare fee is 96.3% for E & M services, 90.6% for surgical procedures,

and 87.7% for medical services and procedures. For E & M services, the Medicare/private sector price ratio is between 0.60 and 0.69 in 57% of localities. For 56% of MSAS, the ratio for surgery is 0.50 or less.

Across localities, the overall Medicare/private sector price ratio ranges from 0.44 to 0.84. In 71 % of MSAs, the Medicare/private sector price ratio for all procedures and services is less than 0.60. Of the 25 MSAs with the highest ratio of Medicare to private sector payment, 20 are in either California or Michigan. The 10 MSAs having the highest Medicare to private sector payment ratio are Vallejo-Fairfield-Napa, CA (0.84); Detroit, MI (0.82); Salinas, CA (0.81); Pittsfield, MA (0.80); Redding, CA (0.80); Spokane, WA (0.80); Ann Arbor, MI (0.77); Flint, MI (0.75); Jackson, MI (0.73); and Yolo, CA (0.73). The 10 MSAs having the lowest Medicare to private sector payment ratio are Augusta-Aiken, GA-SC (0.49); Champaign-Urbana, IL (0.49); Raleigh-Durham-Chapel Hill, NC (0-49); Madison, WI (0.48); Rocky Mount, NC (0.48); Wilmington, NC (0.48); La Crosse, WI-MN (0.47); Iowa City, IA (0.47); Athens, GA (0-47); and Rochester, MN (0.44).

II. Conclusions

For the vast majority of cases, Medicare pays (statistically) significantly less than the private sector. But what can be made of claims that "Medicare is the high payer," and that the Medicare payment gap may be a myth (Miller 1995)? The evidence discussed here indicates that Medicare may be the high payer only in scattered areas and only for a limited number of physician services (as anecdotes also indicate).

One source of data has been cited as "evidence" supporting the notion that the Medicare payment gap may not be what it seems. Articles in American Medical News (Meyer 1995) and the New Republic (Miller 1995) have both discussed analyses based on data from Medirisk, Inc. Other than "findings," there is a general paucity of information about the Medirisk data. What is available is sufficient to discount the generalization that Medicare is the high payer.

Medirisk surveys managed care plans and gathers plan-level fee information. The physician payments appear to be drawn from fee schedules, not transacted prices. As such, they exclude withholds and bonuses, and would not reflect the total reimbursement. Another concern is how the variation in payment rates across plans is affected by not differentiating between separate service components and global services. Also, information is lacking about levels of service utilization that are needed to construct weighted averages and price indices. Consequently, arguing that vast savings could be made through payment reform based upon the Medirisk analyses would be foolhardy.

Endnotes

[1] The PPRC estimate of the national private payment rate is a weighted payment derived from a multi-year (1989-1994), multi-payer database of private sector physician claims and enrollment. The data sources include the Federal Employee Program (FEP) through Blue Cross/Blue Shield plans, a national commercial insurer, and the MEDSTAT Marketscan Database. The FEP coverage is a PPO. The commercial insurer and MEDSTAT data include PPO and indemnity claims. Payments in each dataset include copayments and deductibles, and reflect discounts and fee screens. All three datasets are national in scope, show similar trends, and are internally consistent cross-sectionally — the MEDSTAT payment falls between the FEP (low end) and the commercial payments. This provides a validity check for estimating a nationwide payment rate. The data exclude capitated payments and partial capitation HMO products, however. The physician payment information from these sources is then adjusted downward to reflect HMO fee-for-service payments and shares of HMO revenues in physician practices. All comparisons are based on the Medicare service mix.

[2] CPT codes and descriptors only are copyright American Medical Association.

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Appendix

Data

The Medicare payment data used in the payment comparisons are taken from the Health Care Financing Administration 1993 "Physician Fee Schedule Transition File." Prices are actual 1993 Medicare fee schedule

amounts for participating physicians (i.e., not "full fee schedule" amounts or "average allowed charges"). The payments are determined by the Medicare transition payment formula and vary only by procedure and Medicare physician payment locality. The data were mapped to counties and then from counties to Metropolitan Statistical Areas (MSAs), weighting by county-level Medicare Part B enrollment, to construct an MSA-level price by Current Procedural Terminology (CPT) code. Medicare national frequency data are from the 1993 Medicare Part B Physician/Supplier Procedure Summary File. Records were subjected to edits and trimming to arrive at national counts.

Private sector physician services price and utilization data for 1993 are taken from the AMA Center for Health Policy Research Private Sector Simulation Project (PSSP) Database of Physician Services (Kmetik and Wozniak 1994). The PSSP data are derived from the MEDSTAT Marketscan Database (MEDSTAT Systems, Inc). All claims represent fee-for-service payments through either a preferred provider organization (PPO), point-of-service plan, or indemnity plan. The payments include patient deductibles and copayments. Fee-for-service payments under traditional health maintenance organizations (HMOs) and capitated payments are not included. Claims are compiled from 100 different insurance companies, Blue Cross/Blue Shield plans, and third party administrators across the US for a population of nearly 3.5 million covered lives. The utilization and price information from claims are first aggregated to counties using digit zip code, and then to MSAs weighted by county level frequencies.

There are several exclusions: radiology, anesthesiology, and pathology procedures; other procedures with professional- or technical-only components; all non-metropolitan areas; and all CPT-code/MSA combinations without both Medicare and Private Prices.

Payment Comparison Methodology

First, average Medicare and private sector prices were computed at the CPT-code/MSA level for 1993. Approximately 153,000 CPT-code/MSA combinations remain in resulting analysis file. To perform statistical tests (t-tests) for differences between Medicare and private sector prices at CPT-code/MSA level, only CPT-code/MSA combinations with at least 25 private sector claims were included. The resulting dataset has 19,335 observations on CPT-code/MSA combinations.

Indices of the relative Medicare-to-private price were then constructed at the MSA level, for all services, and three major sub-categories of services: evaluation and management (E & M), surgery, and medicine. Several techniques are available for constructing price indices. These include: a Laspeyres index using national Medicare frequencies for weights; a Laspeyres index with national private sector frequencies for weights; a Paasche index using area-specific (MSA) private sector frequencies for weights; and a Fisher's Ideal index which is the geometric mean of the second Laspeyres index and the Paasche index. Because the results are generally consistent across the indices, only those from Fisher's Ideal index are discussed.

Source: *American Medical Association Center for Health Policy Research*

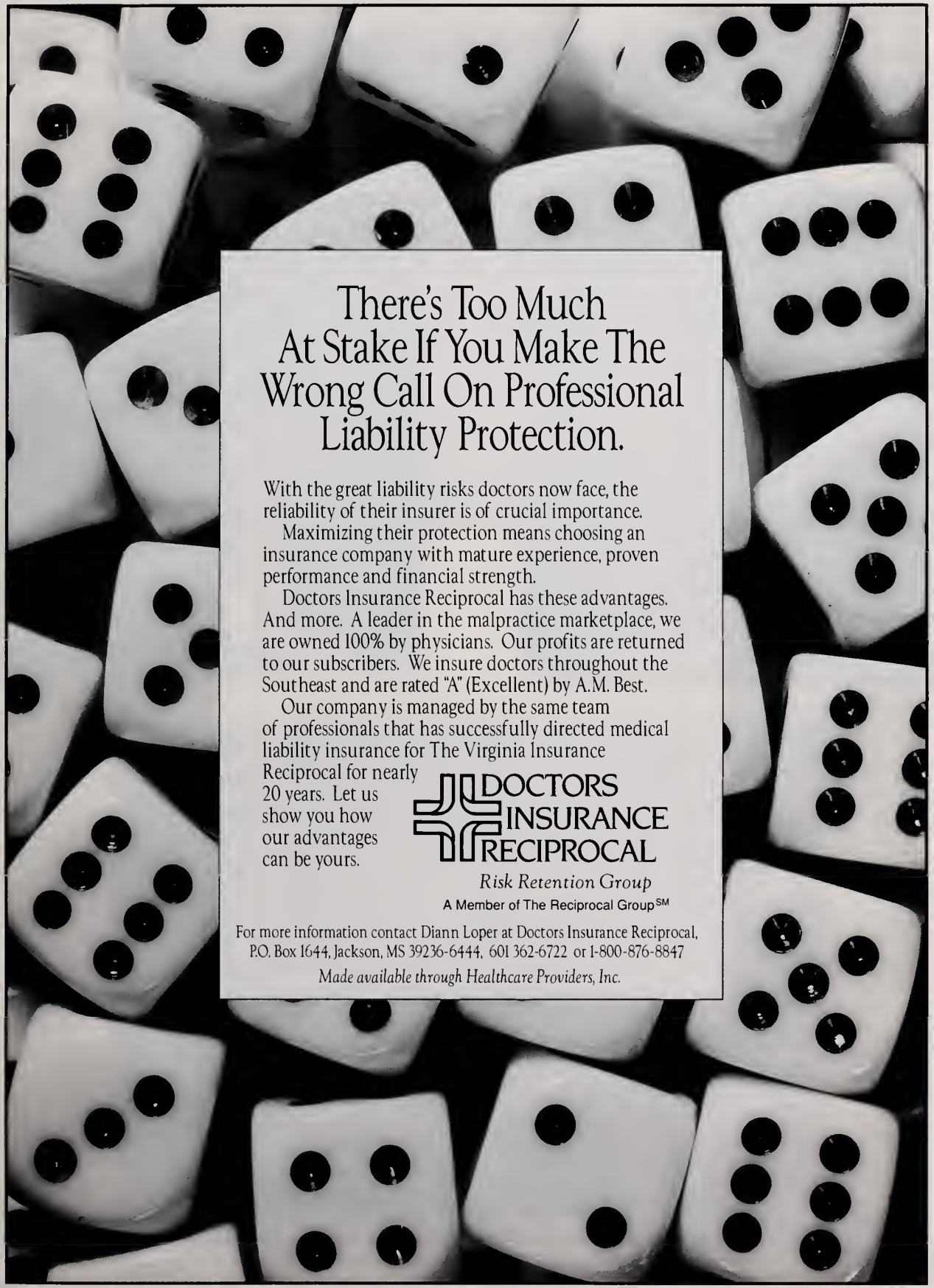


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The MSMA Board of Trustees met Saturday, April 5, 1997 at the MSMA headquarters. At the meeting the Board reviewed the annual audits and finalized its reports to the House of Delegates.



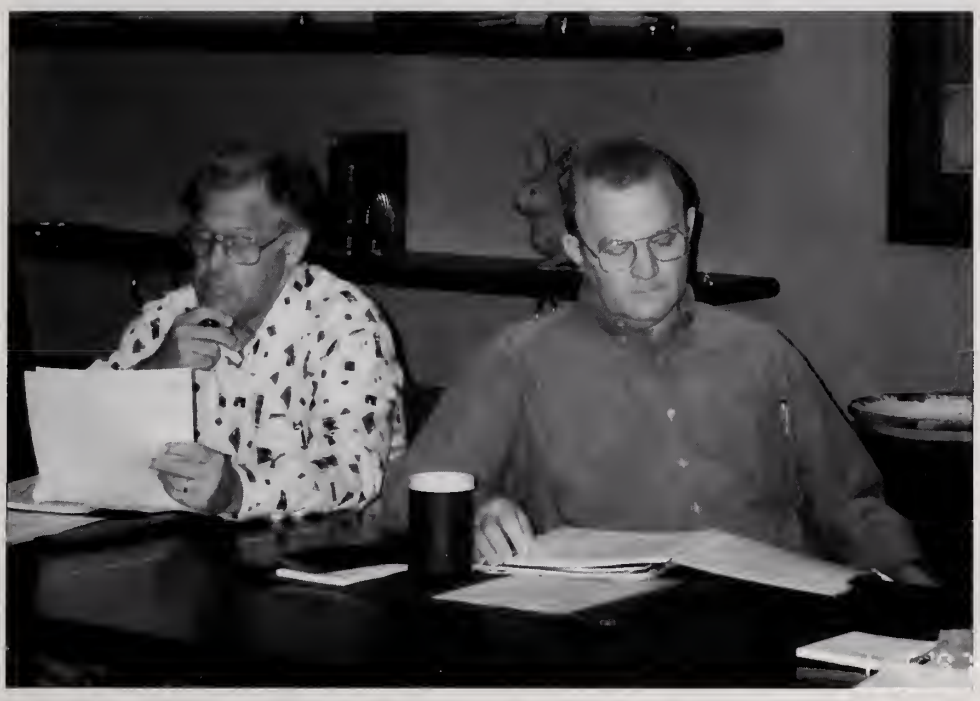
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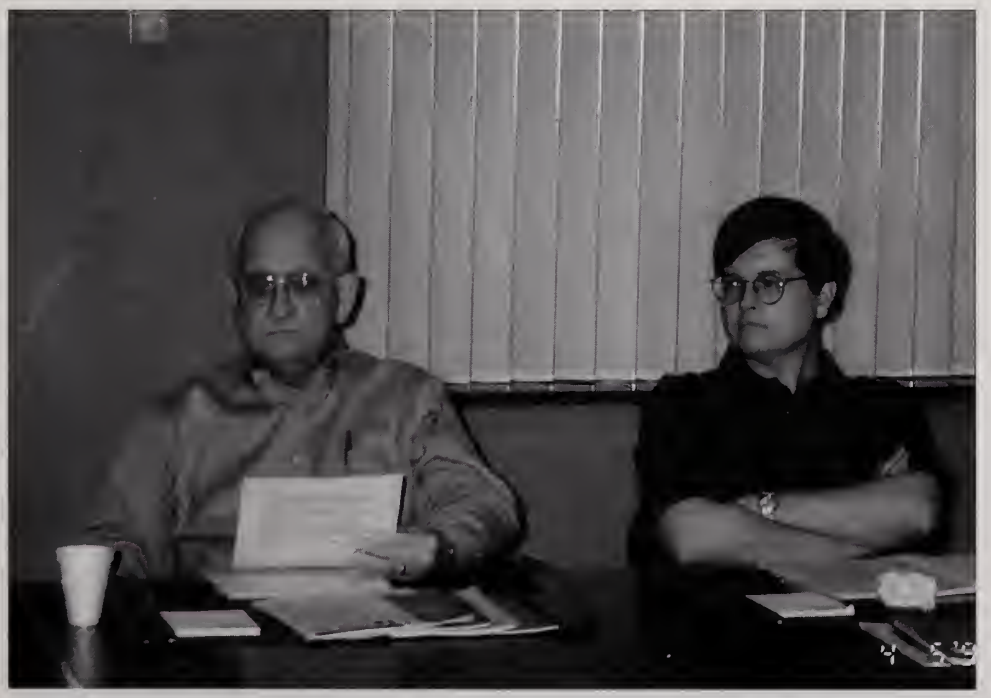
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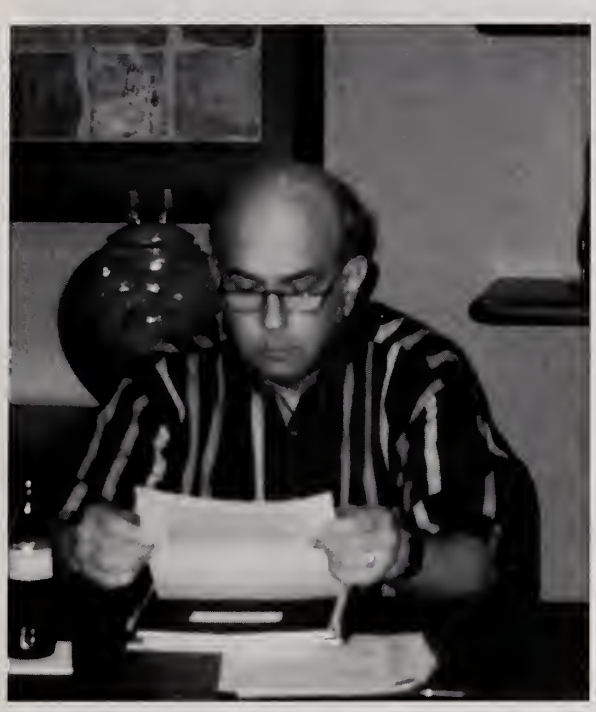
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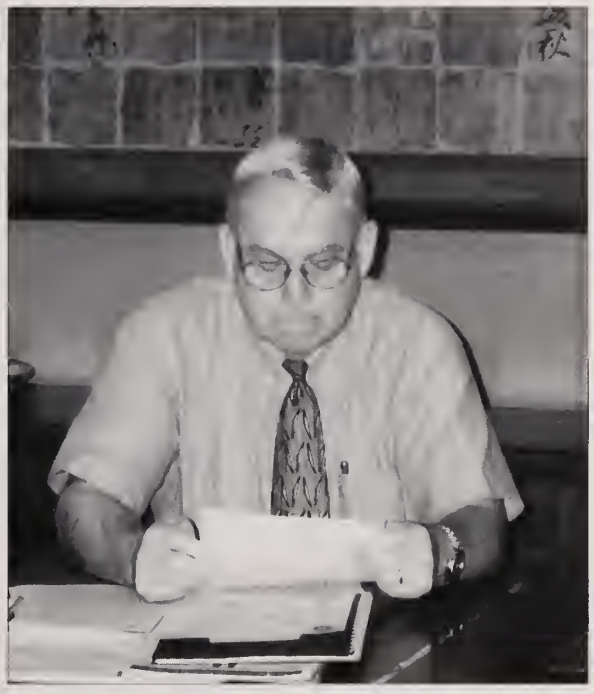
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Carl G. Evers Society Ends First Year With Teaching Awards

An even dozen teachers in the School of Medicine were recognized for teaching excellence at the first awards dinner of the Carl G. Evers Society on March 6.

The Carl G. Evers Society honors the memory of Dr. Carl Evers, associate medical school dean for academic affairs until his death in 1992. He died as the result of injuries in a bicycle accident eight months later. Medical students organized the Evers Society last year to promote discourse between students and faculty and to have a stronger voice in the medical school curriculum. The students saw recognition of teaching excellence as one way of meeting their goals.

Professor of the Year in the basic sciences was Dr. Beth Hoskins, professor of pharmacology and toxicology. Dr. Mervyn P. (Dick) Smith, associate professor of medicine and assistant dean for the coordination of education at the Montgomery VA Medical Center, received top honors as Professor of the Year in the clinical sciences.

Making the "all star" team in the basic sciences were Dr. Greg Mihailoff, professor of anatomy; Dr. John Naftel and Dr. Susan Warren, associate professors of anatomy; Dr. David Conwill; associate professor of preventive medicine and Dr. William Lushbaugh, associate professor of microbiology.

Clinical sciences all stars were Dr. Bernard Dreiling, professor of medicine; Dr. Joe Donaldson, associate professor of pediatrics; Dr. Keith Thomae, assistant professor of surgery; Dr. Judy Gearhart, associate professor of family medicine and Dr. Buford Yerger, assistant professor of orthopedic surgery.

Dena Jackson, Evers Society president and senior medical student, said every student in every year of medical school had an opportunity to nominate someone on the faculty as professor of the year. The student body then voted on the teachers nominated.

"We ended up with 60 different nominations," she said, a number that Jackson thinks indicates the caliber of the faculty at UMC.

"Everyone here is a good teacher. The ones who received the awards are the best of the best."

The awards represent the first time the entire student body has voted on teaching excellence at one time. The Medical Alumni Chapter sponsors annual teaching awards voted on by seniors and sophomores.

Other honorees of the night included Donna Kaye Cassell, president of the senior class last year and the prime mover in organizing the group; vice chancellor Dr. Wallace Conerly, who recognized the need for a student-led organization and urged its establishment; and Jan Evers, widow of Dr. Carl Evers for whom the society is named. Mihailoff and Dr. Will Sorey, assistant professor of pediatrics, received recognition as faculty advisors.

"We just wanted to thank them for their help and cooperation," Jackson said. In addition to the awards for teaching excellence, the society is responsible for the evaluation of courses.

"We're responsible for the entire process of evaluation," Jackson said. "We develop the survey form students use to evaluate their classes. We do the analysis of the data, and write the final report that goes to Dr. Conerly."

Ms. Jackson says members of her class never had the opportunity of knowing Evers as a faculty member. "But everything we heard about him from students who had known him made us want to name the organization for him."

Dr. Helen Turner, who now serves as associate dean for academic affairs, did know Evers when she was a student. During her tribute to him at the society's award dinner, she said, "Dr. Evers had a truly distinguished career in medical education, but I know that he would want to be remembered most for his love of students and for his commitment to their medical education. I know he would be pleased that this organization bears his name."

Med Students Celebrate Pivotal Juncture in Career

The 1997 Match is over. Medical students who've spent the last few months wondering where they'll spend the next three or four years of their career, can breathe easier.

Dr. Helen Turner, associate dean for academic affairs, termed this year's Match "very successful."

Every March, senior medical students learn if they've been accepted into the residency program they most desired. This year 85 percent of the class got their first or second choice.

Of the 90 seniors, 87 participated in the Match. Forty-nine of the seniors will stay at UMC for residency training, and 41 will go to one of 17 other states.

Primary care ranked high with students, of whom 68 percent chose postgraduate training in one of the primary care specialties.

The breakdown was family medicine, 12; internal medicine, 28; ob-gyn, 10; pediatrics, 10; medicine/pediatrics, two; emergency medicine, seven; surgery, 11; anesthesia, two; otolaryngology, three; psychiatry, three; orthopedics, one; and ophthalmology, one.

Turner said the big surprise of the day was the number of students who matched for ob-gyn. "That's a very competitive speciality, and it's unusual to have so many students match for it."

She said the students who had matched for pediatrics at UMC expressed their enthusiasm at the prospect of working in the new Blair E. Batson Hospital for Children, scheduled to open on May 16, just six weeks before the beginning of their training on July 1.

Blood Transfusion Quality Improvement Project Findings

Findings have been released for the Blood Transfusion Quality Improvement Project implemented by the Foundation for Medical Care (FMC) in 1994.

Indicators for the project were developed with the clinical guideline "Practice Strategies for Elective Red Blood Cell Transfusions" by the American College of Physicians and, earlier, a similar statement from the National Institutes of Health Consensus Development Conference. Participating in the project development was a local study group composed of an orthopedic surgeon, an anesthesiologist, a medical director for a regional blood service, and a professor of hematology from the University of Mississippi Medical Center.

The quality indicators are:

- Documentation of estimated blood loss
- Documentation of clinical reassessment prior to each unit transfused (non-single units)
- Use of single unit transfusions when appropriate
- Use of reinfusion device during surgical procedure
- Use of autologous blood

Three hospitals participated in the Blood Transfusion Project. Data were collected from charts of Medicare beneficiaries that had one of the selected procedures (ORIF 79.35, total and partial hip replacement 81.51-81.53, total knee replacement 81.54, 81.55) with discharge dates from Jan. 1, 1993, through June 30, 1993. The results of the analysis provided a baseline for these facilities and showed areas for improvement. One hospital chose not to continue participation in the project. Interventions were implemented by the two participating hospitals, and these hospitals provided FMC with internal follow-up monitoring. FMC has now performed follow-up monitoring on discharges between Aug. 1, 1995, and Oct. 31, 1995.

The baseline study had 397 cases for three hospitals and 97 in the follow up for the two collaborating hospitals.

Findings from all hospitals in the project include:

•The baseline study revealed blood was transfused for 30.48 percent of the 397 patients with an overall average number of units transfused being 1.88; the follow up showed blood was transfused for 29.90 percent of the 97 patients with an overall average number of units of blood being 2.24.

•Follow up showed the average number of units ordered per patient that had blood ordered was 2.47. The total number of units ordered was 136 with 65 units being transfused, a ratio of 2:1, meaning a 48 percent difference between blood ordered and blood transfused. A total of 52 percent of the blood ordered was not transfused. Of particular note, the ratio of units transfused was 6:1 in total knee cases.

•Documentation of estimated blood loss was 52.90 percent in the baseline; follow up increased to 76.29 percent.

•Documentation of clinical reassess-

ment was 1.19 percent in the baseline; in the follow up, it increased to 29.73 percent.

•Of the patients receiving transfusions, the baseline revealed 30.58 percent as single unit transfusion; in the follow up, 10.34 percent were single unit transfusions.

•Use of salvage reinfusion device increased from a baseline of 37 percent to 54 percent in the follow up.

•This was a 7 percent increase in knee procedures and 25 percent increase in hip procedures. This change was also reflected in a 24 percent drop in use of blood transfusions for knee procedures (30 percent in baseline, 6 percent in follow up).

For further information about this project, contact Belinda Moseley, who serves as the project manager, 354-0304.

James S. McIlwain, M. D.
Principal Clinical Coordinator

The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

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Send entries along with a brief description of the subject, as well of yourself, to Karen Evers, managing editor, JOURNAL MSMA, Mississippi Medical Association, 735 Riverside Drive, Jackson, Mississippi, 39202. For more information, contact Ms. Evers at (800) 898-0251, extension 412, or (601) 354-5433.

Equipment Sought for Medical Mission

A Jackson based medical mission organization is in the process of establishing the first American standard hospital in the east African country of Malaivi and seeks used medical equipment in good working condition for that purpose. Any items essential to the establishment of a new hospital are acceptable and all donations are tax deductible. For questions and pick-up arrangements call Dr. Jack Flood (601-981-0926) or Paul Chinchen (601-925-0512). Malaivi has a physician population ratio of 4:100,000 and an infant mortality rate of 143:1,000. Health education will also be an important component of the new hospital's services. There will be two educational programs implemented. The mobile clinic services of the hospital will be utilized to hold classes on nutrition, hygiene and preventive medicine targeted particularly on child care. The clinic's staff will also offer on-site classes leading to a premedicine certificate.

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BLUE, KARL MICHAEL, Laurel. Born Jackson, MS, March 13, 1963; MD Louisiana State University School of Medicine, New Orleans, LA, 1989; internal medicine residency and medical oncology fellowship, Ochsner Medical Foundation, New Orleans, LA, 1989-94; elected by South MS Medical Society.

COSUE, LAMBERTO G., III, Ruleville. Born Manila, Philippines, May 8, 1964; MD University of Santo Tomas Medical School, Philippines, 1989; internal medicine residency, Lutheran Medical Center, Brooklyn, NY 1992-95; elected by Delta Medical Society.

DAR, AYESHA S., Brookhaven. Born Lahora Pakistan, June 26, 1968; MD King Edward Medical College, Lahore, Pakistan; pediatric residency, University of Tennessee School of Medicine, Memphis, TN, 1993-96; elected by South Central Medical Society.

FITZPATRICK, JOHN M., Hattiesburg. Born Galway, Ireland, July 1, 1962; MD , Galway, Ireland, 1985; internal medicine residency and nephrology fellowship, Boston University Medical Center, Bolton, MA, 1990-94; elected by South MS Medical Society.

FRAZIER, CLAUDE CLINTON, III, Bay St. Louis. Born Hattiesburg, MS, August 27, 1948; DO, Kirksville College of Osteopathic Medicine, Kirksville, MO, 1992; internal medicine residency, one year, Franklin Square Hospital, Baltimore, MD; elected by Coast Counties Medical Society.

HAHN, KENNETH AARON, Greenville. Born Chicago, IL, September 29, 1957; MD, University of Health Sciences,/The Chicago Medical School, Chicago, IL, 1983; interned one year, St. Francis Hospital, Evanston, IL; internal medicine residency, same, 1984-96; cardiovascular medicine fellowship, same, 1986-87; Advance interventional, C. M. , University of WI, 1993-95; vascular medicine fellowship, Cleveland Clinic, Cleveland, OH 1995-96; elected by Delta Medical Society.

HAIDER, NAEEM M., Macon. Born Pakistan, October 1, 1966; MD Allama/Qbal Medical College, Lahore Pakistan; internal medicine residency St. Lukes Hospital, New York, 1993-96; elected by Prairie Medical Society.

HOLIFIELD, LARRY T., Laurel. Born May 28, 1957; DO, West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1993; family medicine residency, University Medical Center, Jackson, MS, 1993-96; elected by South MS Medical Society.

KULPA, JANUS J., D'Iberville. Born Poland, April 28, 1960; MD University of Toronto Medical School Toronto, Ontario, Canada, May 1994; family medicine residency, same, 1994-96; elected by Coast Counties Medical Society.

LUCAS, PHILLIP H., Jackson. Born Levelland, TX, July 9, 1949; MD University of Texas School of Medicine, Galveston, TX, 1975; internal medicine residency, Scott & White Memo. Hospital, TX, 1975-78; radiology residency, Baptist Hospital, Memphis, TN, 1980-83; elected by Central Medical Society.

LUZ, VICTOR J., Corinth. Born Philippines, January 2, 1963; MD University of San Tomas, Philippines, 1995; pediatric residency, University of Illinois Medical Center, Chicago, IL, 1991-94; elected by Northeast MS Medical Society.

MAHLER, D. MARK, Jackson. Born Ohio, March 31, 1951; MD Ohio State University College of Medicine, Columbus, OH, 1976; pediatric residency, Montefiore Hospital and Medical Center, Bronz, New York, 1976-79; elected by Central Medical Society.

MALLOY, DAVID S., Meridian. Born St. John NB, Canada, November 25, 1956; MD Dalhousie University, Halifax NS Canada, 1979; surgery residency, same, 198-85; neurosurgery residency, Univ. of Toronto, 7/85-12/85 and UCSD, San Diego, CA 1/86-6/86; elected East MS Medical Society.

OSMAN, KHIDIR, Jackson. Born Sudan, January 1, 1956; MD Khartoum, Sudam, 1983; internal medicine residency, University Medical Center, Jackson, MS, 1987-90; cardiology residency, same, 1990-93; elected by Central

Medical Society.

PERSING, RONALD E., Pascagoula. Born Sioux, SD, November 21, 1950; MD University of South Dakota School of Medicine, Vermillion, SD, 1977; pediatric residency, Wilford Hall USAF Medical Center, Lackland, AFB, TX 1977-80; adolescent medicine fellowship, Fitzsimmons Army Medical Center, Aurora, CO, 1984-86; elected by Singing River Medical Society.

PUPA, LAWRENCE E., JR., Meridian. Born February 11, 1954; MD University of Cincinnati School of Medicine, Cincinnati, OH, 1980; internal medicine residency, Brooke Army Medical Center, Ft. Sam Houston, TX, 1980-83; cardiology residency, same, 1983-86; elected by East MS Medical Society.

ROBERTSON, DENZIL G., Macon. Born March 6, 1967; MD University of the West Indies, Jamaica, WI, 1990; internal medicine residency, Brooklyn Hospital Center, Brooklyn, NY 1993-96; elected by Prairie Medical Society.

SALMAN, MICHAEL T., Jackson. Born Long Beach, CA, July 11, 1956; MD Medical College of Wisconsin, Milwaukee, WI, 1988; one year internship, John Peter Smith Hospital, Fort Worth, TX; anesthesiology residency, Parkland Memorial Hosp., Children's Medical Center, Scottish Rite Hosp., Dallas VA Medical Center and University of Texas Southwestern Medical School & Affiliated Hospitals, 1989-92; elected by Central Medical Society.

SHOWS, SCOTT T., Meridian. Born October 4, 1955; MD University of Mississippi School of Medicine, Jackson, MS, 1985; interned and anesthesiology residency, University Medical Center, Jackson, MS, 1985-89; elected by East MS Medical Society.

SNYPES, STEPHEN RAY, Jackson. Born Mobile, AL, June 10, 1964; MD University of South Alabama College of Medicine, Mobile, AL 1990; interned one year, University of South Alabama Medical Center, Mobile, AL; general surgery residency, Ochsner Hospital & Clinic, New Orleans, LA, 1991-92; anesthesiology residency, University of South Alabama Medical Center, Mobile, AL, 1992- 95; elected by Central Medical Society.

STIMPSON, KIM D., Tupelo. Born Ogden, Utah, June 25, 1955; MD Medical College of Ohio, Cincinnati, OH, 1985; surgery residency, St. Luke Hospital, Cleveland, OH, 1986-80; orthopaedic surgery residency, New England Baptist Hospital, Brookline, MA, 1990-91; elected by Northeast MS Medical Society.

TAKKALLAPALLI, RAMARAO, Jackson. Born Warangal, India, January 2, 1952; MD Osmania Medical College, India, 1978; one year internship, Northshore University Hospital, New York, 1992- 93; anesthesiology residency, University of Mississippi Medical Center, Jackson, MS, 1993-96; elected by Central Medical Society.

TALTON, DAVID S., Tupelo. Born North Carolina, December 2, 1963; MD Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, NC, 1990; general surgery and cardio thoracic surgery residency, University Medical Center, Jackson, MS 1990-96; elected by Northeast MS Medical Society.

WALLER, FRANKLIN W., Columbia. Born Pine Bluff, AR, February 13, 1956; MD University of Arkansas College of Medicine, Little Rock, AR, 1982; family medicine residency, Fayetteville, AR, 1982-85; elected by South MS Medical Society.

WILSON, YOLANDA W., Jackson. Born Chicago, IL, October 9, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1989; pediatric residency, same, 1989-92; elected by Central Medical Society.

DEATHS:

GALLOWAY, SAMUEL C., Booneville. Born December 13, 1915 in Plant City, FL; MD University of Illinois School of Medicine, Chicago, IL, 1950; one year internship, Illinois Central Hospital, Chicago, IL; died March 6, 1997, age 81.

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Guy T. Vise Jr., M.D. of Jackson has been elected to the Board of Trustees of the Orthopaedic Research and Education Foundation (ORF).

Edward J. Shumski, M.D. has been re-elected chief of staff of the medical staff at Biloxi Regional Medical Center. Serving on the Executive Committee as vice president is **Dr. David Harris.** Other MSMA members serving as section chairmen for 1997 are: **Dr. Roger Bradford, chief of family practice;** and **Dr. Daniel Richardson, chief of surgery.** Dr. Shumski is a staff pathologist at Biloxi Regional and has been assistant medical director of the medical center's laboratory and lab annex since 1990.

James Fite, M.D. of Grenada, has been elected vice-president of the the Mississippi Chapter of the American Academy of Pediatrics for 1997-1998. Dr. Fite is currently in private practice in general pediatrics in Grenada. He is also an active member of the medical staff of Grenada Lake Medical Center and is a Clinical Assistant Professor of Pediatrics and a visiting professor at the University of Mississippi Medical Center in Jackson. Dr. Fite has sat on numerous committees and organizations related to child health and welfare. Dr. Fite received his medical degree from the University of Mississippi Medical Center.

Jim Barnett, M.D. of Brookhaven was recently the guest speaker for the Associate Degree nursing occupational strategies class and the Licensed Practical Nursing students at Copiah-Lincoln Community College. Dr. Barnett discussed issues affecting the health care community such as the construction of the new mental health complex in Brookhaven, as well as the physician assistants bill that is before the House and Senate this session. He also discussed the future of health care and the future of nurses in the health care community. Dr. Barnett extended an invitation to the nursing students to come see the legislature in session. The ADN class of 1997 took him up on the invitation during a student nurses convention in Jackson. The nursing students were given a personal tour of the State Capitol by Dr. Barnett.

J. Edward Hill, M.D. of Tupelo, who serves as a member of the AMA Board of Trustees, led a managed care conference, "Shaping the Change-Staying the Course," sponsored by the Mississippi Academy of Family Physicians and the Foundation for Medical Care. The conference, held in Jackson, is available on video-tape. Speakers from throughout the state and nation explored various aspects of managed care such as emergency care, public health issues and quality concerns. For more information about viewing the tape contact the Foundation's communications department at (601) 354-0304.

Catherine A. Thompson, M.D., a family physician at Wiggins Clinic, a service of Hattiesburg Clinic, successfully completed the American Board of Family Practice recertification examination. Dr. Thompson received her medical degree from the University of Mississippi School of Medicine in Jackson. She then completed an internship and residency in family practice at the University of South Alabama in Mobile, Albama.

Ed Rafique, M.D., medical oncologist at North Central Mississippi Regional Cancer Center, recently attended the 38th annual meeting of the American Society of Hematology in Orlando. The society represents more than 8,000 clinicians and scientists committed to engaging in charitable, scientific and educational activities that promote and foster the exchange and diffusion of information and ideas relating to blood, blood-forming tissues and blood diseases. Dr. Rafique is board certified in Internal Medicine by the American Board of Internal Medicine; board qualified in Hematology by the American Board of Hematology and board qualified in Medical Oncology by the American Board of Medical Oncology.

Ralph Phillip Wells, M.D., has been named the Methodist Medical Center's chief of staff for 1997. Wells is board certified and joined Methodist Medical Center's Jackson Radiology Associates in 1986. He received his doctorate of medi-

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

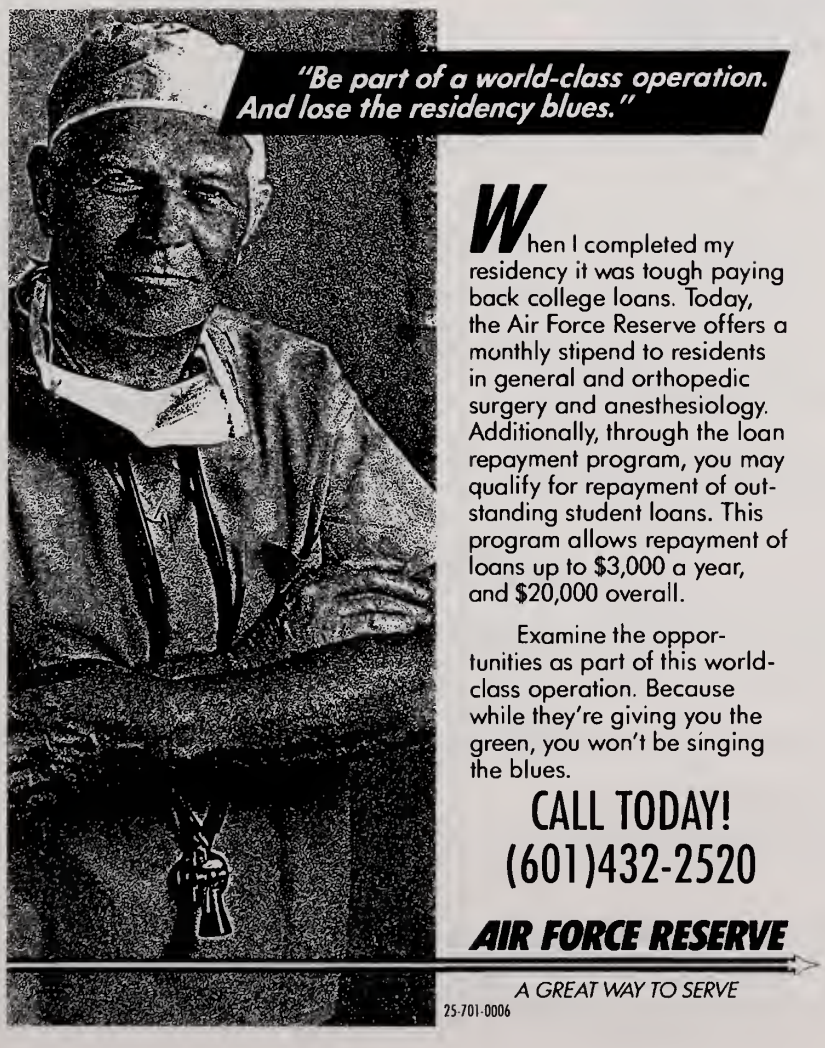
cine from University Medical Center's School of Medicine in 1982 and completed his residency in diagnostic radiology at the University of Florida Health Sciences Center in Jacksonville, Florida. From 1993-1994, Wells served as Methodist Medical Center's chief of medicine. He is the medical doctor for the radiology department there and serves as the president of the Mississippi Radiology Society.

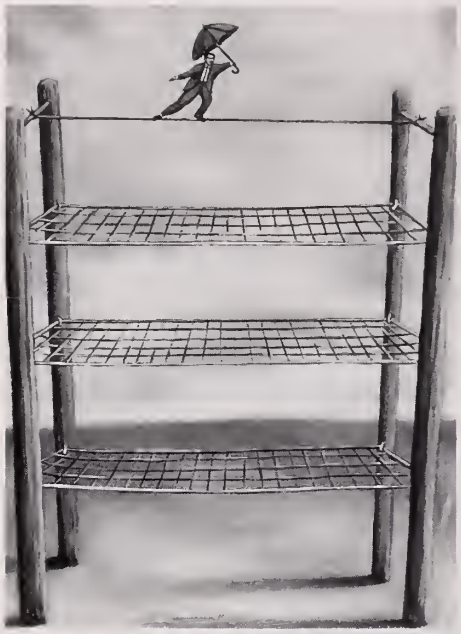
A.M. (Mac) Adams Jr., M.D. has joined the family of primary care providers at Baptist Memorial Health Care of Mississippi. Dr. Adams has been in family practice for many years in the Tate County area.

William C. Warner, M.D., who specializes in sports medicine in the Jackson area, received an award for his contributions to amateur football during a ceremony at the Mississippi Sports Hall of Fame.

Edgar Hull, M.D., medical oncologist/internal medicine specialist on the Singing River Hospital, has become board certified with the American Board of Hospice and Palliative Medicine. Dr. Hull serves as the medical director of the Hospice of Light, Singing River's service for the terminally ill. He is also the medical oncology director for the Regional Cancer Center at Singing River where he has been since 1979.

Rebecca Hodges, M.D. of Kilmichael has completed continuing medical requirements to retain Active membership in the American Academy of Family Physicians (AAFP), the national association of family doctors. AAFP members are required to complete a minimum of 15 hours of accredited continuing medical study every three years. The AAFP, which has more than 75,000 members, is one of the largest medical specialty organizations in the country. It was the first national medieal group to require members to keep up with medical advancements through regular continuing medical education. Dr. Hodges has been an Active AAFP member since 1981.





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The Family Practice opportunities are located in Oxford and nearby Pontotoc. Join a two-physician group in Oxford with special interest in allergy and industrial medicine. The clinic is new construction with dedicated laboratory and x- ray. Another opportunity in nearby Pontotoc provides a new 6,000 square foot clinic with dedicated laboratory and x-ray in a growing medical community. Both opportunities provide excellent benefits and pay with the option of income guarantee or salaried positions. **Call Peyton Warrington at 1-800-264-8104 for more information on this and other opportunities.**

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The position is available on July 1, 1997 or as agreed to by applicant and the Director. Applications will be accepted until the position is filled. Send applications that include: a letter of interest, a current CV, and at least three references to: Chair of Physician Search Committee, Box 9732, Mississippi State, MS 39762. MSU is an AA/EEO employer.

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Managed Care Contracts...Protecting Your Rights

Managed Care. You may not be able to fight it -- but there are things you can do to protect yourself both now and in the future.

We talked with Dr. Edward Hill, who has recently joined the staff of North Mississippi Medical Center in Tupelo, where he serves as Medical Director of the Family Medical Clinics and Director of the Family Practice Residency Program.

"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

Physicians should keep in mind that they can negotiate the terms of their contracts, as Dr. Hill did when he made his recent move to Tupelo. You can reserve certain rights, such as choosing your malpractice insurance company.

"Tying the physicians' coverage into the hospital's might offer some reduction in premium for the hospital, but there is much more that the physician should consider than just the bottom line," Hill added. "I was not willing to give up the benefits I receive through a physician-owned company like Medical Assurance."

Several Mississippi physicians recently learned this lesson the hard way. The hospital, against their wishes, switched their professional liability insurance to the hospital's carrier. The physicians lost more than the equity investments they had with Medical Assurance Company -- they also lost their right to be involved in any decision regarding settlement of claims against them. Now those decisions are made by the hospital administrator and an out-of-state insurance company.

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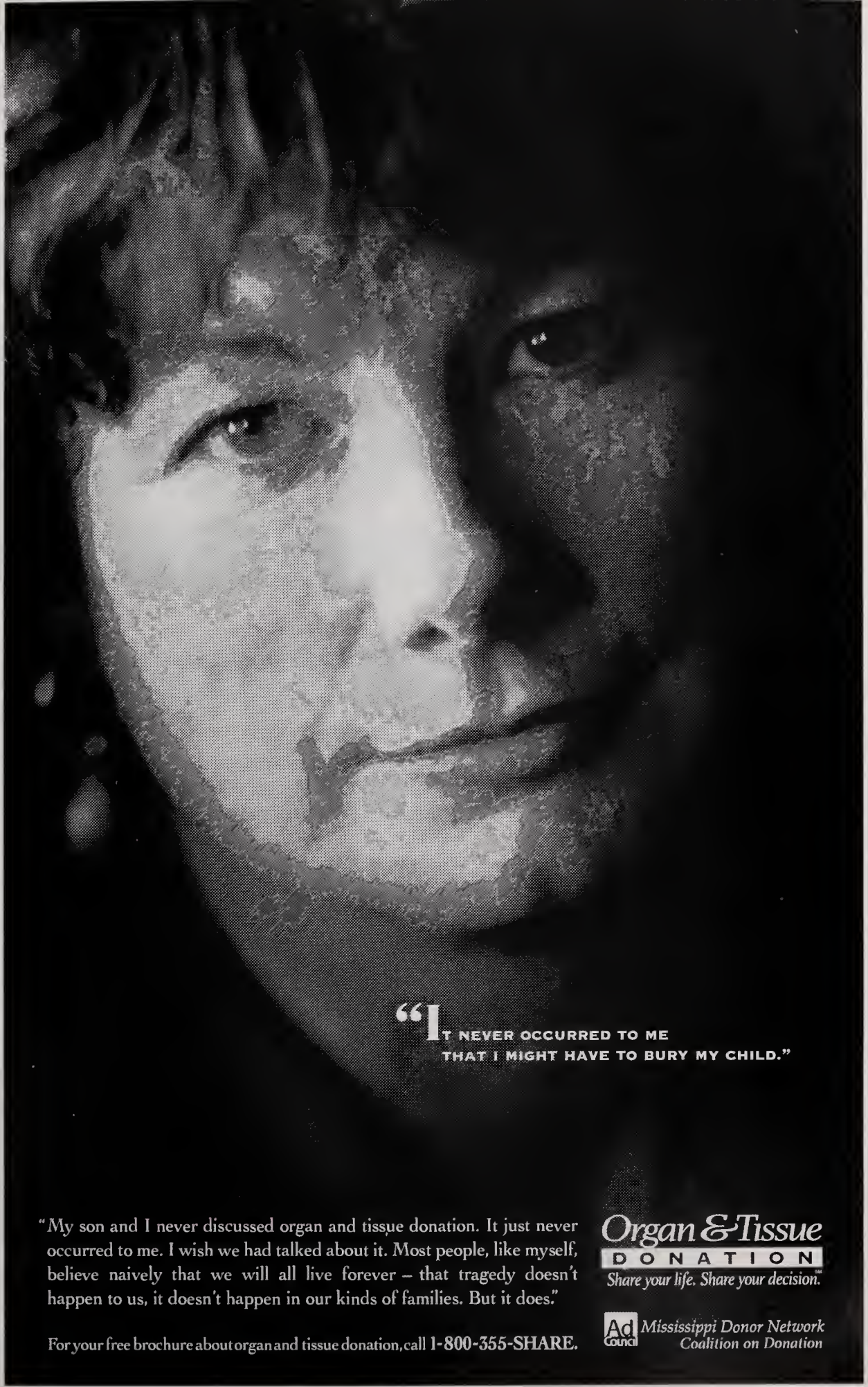


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- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.

- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.

- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.

- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.

- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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Common Afflictions of the Hand

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Prevention, Diagnosis and Treatment of Viral Hepatitis

Billy W. Long, M.D.

This report is the second of a series of presentations made by Mississippi physicians at the annual St. Dominic's Winter CME meeting in Park City, Utah.

Key Words

HAV	**Hepatitis A virus**
HBV	**Hepatitis B virus**
HBsAg	**Hepatitis B surface antigen**
HBsAb	**Hepatitis B surface antibody**
HBeAg	**Hepatitis B "e" antigen**
HBcAb	**Hepatitis B core antibody**
HCV	**Hepatitis C virus**
HCVAB	**Hepatitis C Antibody**
HCV RIBA	**H epatitis C recombinant immunoblot assay**
HCV RNA PCR	**Hepatitis C RNA by polymerase chain reaction**
HCV RNA BDNA DNA	**Hepatitis C RNA by branched amplification**
HDV	**delta agent viroid**

Introduction

This report concerns the five major hepatotrophic viruses documented to cause acute or chronic hepatitis. These viruses have been named A, B, C, D and E.

Hepatitis A

Hepatitis A virus (HAV) is transmitted by the fecal-oral route from person to person or by contaminated food, water, or bivalve mollusks. The incubation period is approximately one month. Infection with any strain of HAV provides a high level of protection against future infections by genetically divergent strains. HAV infection is endemic in developing countries, with most children infected by the age of five. However, in developed countries the prevalence of the antibodies to HAV has fallen to 5% to 10% in young adults. Therefore, there is now a large population susceptible to HAV

in developed countries such as the USA. Severe HAV hepatitis is more common in older persons. Infants and young children with acute HAV hepatitis may have fewer symptoms. There is no chronic form of HAV hepatitis. The diagnostic tests include IgM antibodies to HAV which are detectable in acute hepatitis.

Immunization can be given both actively and passively. Passive immunization is obtained by intramuscular injections of human immunoglobin. Active immunization is now possible through a new aluminum hydroxide-absorbed vaccine. Vaccinations require two injections given one month apart. Some persons may need an additional booster injection six months after the initial treatment. Both Smith-Kline-Beecham and Merck make the hepatitis A vaccine. Children and young adults in the United States who anticipate travel to underdeveloped countries where exposure to HAV might be expected should receive the vaccine. In addition, armed forces personnel, diplomats, staff of children's day care centers, and staff of institutions for intellectually handicapped should also be given the HAV vaccine. Male homosexuals, IV drug abusers, hemophiliacs, and sewage workers are also at increased risk for HAV and should be vaccinated.

Hepatitis B (HBV)

Since Hepatitis B (HBV) virus was discovered in 1970, the incidence has increased 37% in the United States in the last ten years due to the influx of immigrants from endemic areas and to IV drug abuse. Three hundred thousand new cases occur annually, and about 1.25 million persons in the USA are chronically infected with the HBV virus. Five thousand people die annually from HBV infection; 300 of these are health care workers. Worldwide 2 billion people are infected with the HBV. Diagnosis is made by detecting HBsAg in the blood, and infectivity correlates with detection of the HBeAg in the blood. An IgM antibody to hepatitis B core (HBcAb) indicates an acute infection. Chronic disease may be indicated by detection of HBsAg, HBeAg and lack of HBsAb.

Transmission of Hepatitis B is primarily blood borne. The incubation period may range from two weeks up to two months for HBV. The majority of the cases in the United States are transmitted by IV drug abusers sharing needles or by sexual transmission through semen and vaginal secretions. A large percentage of the transmission occurs by unknown means, such as tattoos, sharing tooth brushes, chewing gum, and razors. Transplacental or perinatal transmission also occurs.

Prevention should include vaccination of all high risk groups. High risk groups include health care workers exposed to blood, needles, or body fluids, and all health science students, male homosexuals, promiscuous heterosexuals, IV drug users, and workers and clients in mental institutions. Some have recommended that all infants and all students entering junior high school be vaccinated.

The vaccine must be given in the arm and not in the buttocks to be effective. The recombinant vaccine is safe and 85% to 95% effective in preventing infection with hepatitis B. Chronic hepatitis B occurs in 10 to 15% of the patients infected with the hepatitis B virus. Chronic hepatitis B can be treated with interferon or transplantation. New data indicates that antiviral therapy with Lamivudine may be effective. Cirrhosis and hepatocellular carcinoma may develop in those individuals with chronic HBV infection.

Hepatitis C (HCV)

Hepatitis C (HCV) was first identified in 1989. It is one of at least four non-A non-B viruses. The C virus causes 20% of post transfusion hepatitis. In May 1990 a commercially available test for hepatitis C antibody became available. There are approximately 170, 000 new cases annually, and 50% to 75% of patients who have hepatitis C will become chronic carriers. Cirrhosis and hepatocellular carcinoma may develop in patients who are chronically infected with HCV. Diagnosis of HCV includes an antibody to HCV which may take six months to appear. If the HCV antibody is positive, a recombinant immunoblot assay (RIBA) should be obtained to confirm the diagnosis and to eliminate the possibility of a false positive HCV antibody test. Hepatitis C RNA by polymerase chain reaction may be obtained for a more sensitive qualitative diagnosis. HCV-RNA by branch DNA amplification may be used to quantitate the viral titers and monitor the effectiveness of therapy. Transmission of hepatitis C is mainly blood borne. Eighty-two percent of hemophiliacs are infected with HCV, and 88% of patients given HCV positive blood will develop hepatitis. IV drug users carry a 42% risk of acquiring HCV infection. There is a low level of sexual transmission, perinatal transmission, and transmission to health care workers. Treatment of HCV includes interferon therapy and antiviral therapy. Interferon therapy is more effective if phlebotomy is used first for patients with elevated hepatic iron. Antiviral therapy is still experimental. There is no vaccine for HCV, and prevention depends on the use of universal precautions. Hepatitis C can produce extra-hepatic manifestations which include: essential mixed cryoglobulinemia,

membranoproliferative glomeru-lonephritis, porphyria cutanea tarda, and, possibly, autoimmune thyroiditis and Mooren corneal ulcers.

HEPATITIS D (HDV)

Hepatitis D (HDV) is a defective RNA virus known as the Delta agent. It is similar to viroids and requires helper function from hepatitis B. It occurs only in persons infected with hepatitis B. The two infections may be acquired simultaneously, or hepatitis D may occur as a super infection in chronic carriers of hepatitis B. The clinical course is more severe than hepatitis B infection alone. Hepatitis D infection is uncommon in the United States. Hepatitis B vaccine protects against the development of hepatitis D.

HEPATITIS E (HEV)

Hepatitis E (HEV) is a RNA virus and is a common cause of epidemics of non-A non-B hepatitis. Young adults may acquire this infection during water borne epidemics after flooding in areas with poor sanitation. Outbreaks have occurred in underdeveloped areas such as Mexico, India, North Africa, the former Soviet Union, and Nepal. In the United States only travelers from these endemic areas have been reported with hepatitis E. HEV infection during pregnancy carries a 20% fatality rate caused by fulminant hepatic failure. There is no known prevention, and caution should be used by anyone traveling to endemic areas.

In summary, we have newer diagnostic tests to diagnose infections with hepatitis A,B,C and the Delta agent. There is a new vaccine for hepatitis A that should be used by persons raised in the United States who may, through their work or travel, come in contact with hepatitis A. Hepatitis B vaccine is safe and effective and should be given to all health care workers. Hepatitis C is a serious form of hepatitis with a high rate of chronicity leading to the development of cirrhosis and hepato-cellular carcinoma. Interferon therapy has been used with some success to treat chronic hepatitis B and chronic hepatitis C infections.

Dr. Billy W. Long *of Jackson practices internal medicine and specializes in gastroenterology.*



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Common Afflictions of the Hand

Michael E. Jabaley, M.D.

This report is the third of a series of presentations made by Mississippi physicians at the annual St. Dominic's Winter CME meeting in Park City, Utah.

INTRODUCTION

All physicians in clinical practice are asked from time to time why certain parts of the hand or wrist hurt, swell, or "go numb". The pathologic processes of such Complaint:s are subtle, but are easily understood, even by the non-hand surgeon. An appreciation of the conditions which frequently occur can be helpful to practitioners who must advise patients about the need of proper treatment and obtaining appropriate diagnostic studies.

The following conditions were selected because they are among the most frequent ailments encountered in a hand surgery practice. Although treatment in the majority of patients with these problems may require a hand surgeon, they usually have their first encounter with a primary care physician who must make a tentative diagnosis and appropriate referral. Because of time limitations, trauma, infection, tumors and congenital problems are excluded from this presentation. All the conditions described herein are acquired; their etiology may not be known.

MUCOUS CYST OF THE DISTAL PHALANX

The Complaint: A lump on the dorsum of the distal phalanx of a finger or thumb, just proximal to the nail. Change in size is common. It may drain, be tender, deform the nail, or appear unsightly.

Findings: A smooth mass, fixed and covered by thin epithelium, ranging from 2-3 mm to 1.5 cm. There may be a longitudinal groove in the nail. Frequently seen with Heberden's nodes, angulation of fingertips. X-rays usually show osteoarthritis, especially in distal interphalangeal joint.

Pathophysiology: Osteophyte formation in arthritis results in capsule weakness. With flexion, joint pressure increases and fluid is squeezed out into soft tissue and cannot reenter the joint. The body forms a cyst, which remains connected to the joint. Similar to ganglion cysts of other areas (next topic).

Treatment: No effective nonsurgical treatment exists. Aspiration or "lancing" are contraindicated. Surgery (outpatient and digital block anesthesia) consists of excision of the cyst and offending osteophytes. Recurrence is rare.

GANGLION CYST

The Complaint: Larger mass, usually located on dorsal or volar surface of the wrist, but can be on dorsum of hand or flexor tendon sheath. May cause vague pain

with activity but are otherwise asymptomatic. In the main, patients don't like "the lump".

Findings: Again, a smooth mass, minimally moveable, non-tender and transilluminates. On flexor tendon sheath, is small (pea-sized) firm, and does not move with flexion. Usually tender to palpation.

Pathophysiology: These cysts (ganglion, mucous cysts, ganglion cyst of tendon sheath) all represent variants of the same process. Unfortunately, the names vary with their location. All are filled with a clear, thick jelly-like fluid which is the residue of joint fluid from which the water has been absorbed. They generally result from a one-way valve mechanism which occurs at a weakness in the joint capsule or about the tendon sheath.

Treatment: The classic treatment, "hitting with the family Bible," is painful and rarely effective for more than a few days. Cysts can be aspirated or ruptured subcutaneously with local anesthesia and this sometimes is curative. The definitive treatment is surgical excision, with care to remove the neck of the cyst as it dives deep to the joint. Failure to do so, result in prompt recurrence.

TRIGGER FINGER - DE QUERVAIN'S DISEASE (STENOSING TENOSYNOVITIS)

The Complaint: PAIN - all tenosynovitis has in common that it hurts; at times, may be exquisitely painful. Depending on the location, there also may be swelling, tenderness to touch, or pain with movement of the involved digit.

Findings: Visible swelling may exist and there is usually tenderness to palpation. The classical sign is "locking" of one or more fingers in the "trigger-pulling position". A nodule is sometimes palpable on a tendon at the level of the transverse palmar crease and a palpable De Quervain's "pop" can be felt as the tendon moves back and forth with flexion/extension. In De Quervain's, there is always tenderness and sometimes swelling along the course of the thumb extensors at the wrist. Folding the thumb into the palm and ulnarly deviating the wrist (Finklestein's test) can be exquisitely painful.

Pathophysiology: As tendons pass through pulleys and sheaths, they are wrapped in and lubricated by synovium. Any inflammatory condition of the synovium will cause swelling pain and decreased gliding of the tendon. Movement of the tendon is akin to rebound tenderness in peritonitis.

Treatment: NSAID'S (nonsteroidal anti-inflammatory drugs) are often helpful, along with simply resting the part. To this end, splint immobilization is effective. Steroid injections into the synovium can be curative if performed early in the course of the disease. Relief can be from a few weeks to several months and injections can be repeated. Definitive treatment is surgical release of the involved sheath and is sometimes combined with removal of inflamed synovium (synovectomy). Surgery is outpatient with local anesthesia.

DUPUYTREN'S DISEASE

The Complaint: A nodule or a pit in the palm of the hand appears early. Later, a tight longitudinal cord forms, producing contracture of one or more fingers. These are rarely ever painful, so the process may be advanced when first seen. Family history is frequently positive.

Findings: A non-tender nodule or skin dimple precedes or occurs with the contracting is frequently bilateral. A similar process in the feet or penis (Peyronie's Disease) may accompany Dupuytren's Contracture.

Pathophysiology: "The Curse of the Vikings" is transmitted as an autosomal dominant and is more frequent in males. The cause of the contracture is not known but it begins as an inflammatory condition in the palmar fascia which then progresses to contracture. Myofibroblasts have been identified in contractures and probably play a role.

Treatment: Nonsurgical treatment, splinting, and or therapy are ineffective although steroid injections are sometimes used for nodules. Surgery is indicated only for symptomatic contracture, usually greater than 30 degrees. It consists of operative removal of the offending fascia from the palm and fingers and is usually tantamount to cure, although the disease process can extend to other areas later on.

CARPEL TUNNEL SYNDROME ULNAR TUNNEL SYNDROME

The Complaint: Nerve entrapment of the median or ulnar nerves produces a classic set of symptoms which is not mimicked by other diseases. There may be numbness, either intermittent or constant, in the thumb, index, long, and half of ring fingers. It frequently awakens people at night but may occur during daylight hours when driving, holding a telephone or newspaper, operating a keyboard or other machines. There may also be weakness of grip and atrophy of the intrinsic muscles in chronic cases. "I drop things" is a frequent complaint.

Findings: Detectable numbness in the sensory territory of the median or ulnar nerve, atrophy of the thenar muscles, or intrinsic muscles are the hallmarks. Tinel's sign paraestesias on percussing the nerve) may be present and Phalen's test (onset of symptoms with forced wrist flexion) may be positive. Electrical studies can be

helpful when the diagnosis is unclear, but they are not mandatory.

Pathophysiology: Nerve compression may occur where nerves pass through a defined space such as the carpal canal or Guyon's (ulnar) canal. Symptoms occur whenever the contents of the canal are increased in size or the space decreases in size. Compression of sensory nerve fibers produces numbness (intermittent early, but constant in late cases). Compression of motor fibers causes weakness or (later) muscle atrophy.

Treatment: CTS in early stages can be successfully treated by wrist-neutral night-splinting, NSAIDS, weight loss, diuretics, and alteration of the work place but not by acupuncture or chiropractic. Steroid injections to the carpal canal can be therapeutic as well as an evocative test. Surgical treatment consists of operative opening of the area in question- either the carpal tunnel or Guyon's Canal. The success rate is high and recurrences are extremely low in carefully done surgery.

OSTEOARTHRITIS

The Complaint: a) Heberden's nodes - these are frequently tender and unsightly. There may be angulation of the joint and motion is usually reduced. X-rays are diagnostic; Heberden's nodes, in reality, are osteophytes about the DIP joints of the fingers (for which they show a curious predilection). The most common complaint is pain when they are bumped. b) PIP Joint deformity - pain on flexion and decreased motion with associated swelling and tenderness are the hallmarks of synovitis of the PIP joints. Much less common than Heberden's nodes but more serious in import, because of decreased motion and functional impairment, X-rays are diagnostic. c) Trapezio-metacarpal arthritis (base of thumb disease) - pain at the base of the thumb, with gripping of tools or with pinch against the side of the index finger is characteristic of osteoarthritis at this location. A pronounced "bump" can be seen at the base of the thumb and X-rays of the trapezio metacarpal joint will demonstrate the underlying pathology, which is osteophyte and cyst formation with narrowing of the joint space and subluxation of the first metacarpal on the trapezium. The disease is often bilateral.

Treatment: The first line of treatment in all arthritic problems is medical; NSAID'S, splinting, and avoidance of those activities which bring on pain are effective in the vast majority of cases. Those patients referred to the hand surgeon are sometimes sprinted, injected with steroids, and educated about joint sparing maneuvers. In the rare cases where surgery is required, it is for pain relief, restoration of function, and improvement in appearance.

Heberden's nodes are treated by excision of osteophytes and smoothing of bone to reduce the prominence and making them less susceptible to trauma. PIP deformities require either arthrodesis (fusion) or resection of the joint and replacement with silicone implants. This technique is highly effective when medical treatment fails. Resection arthroplasty of the Trapezio-metacarpal joint is the treatment of choice for basilar joint disease. The offending bone is removed and a split tendon from the wrist is used to reconstruct the capsule and stabilize the base of the thumb. In personal cases, this treatment has been effective well over 90% of the time and the pain relief for otherwise recalcitrant arthritis has been gratifying. Surgery is performed only in severe instances because the operation and rehabilitation are of greater magnitude than other conditions listed.

TENNIS ELBOW (lateral epicondylitis)

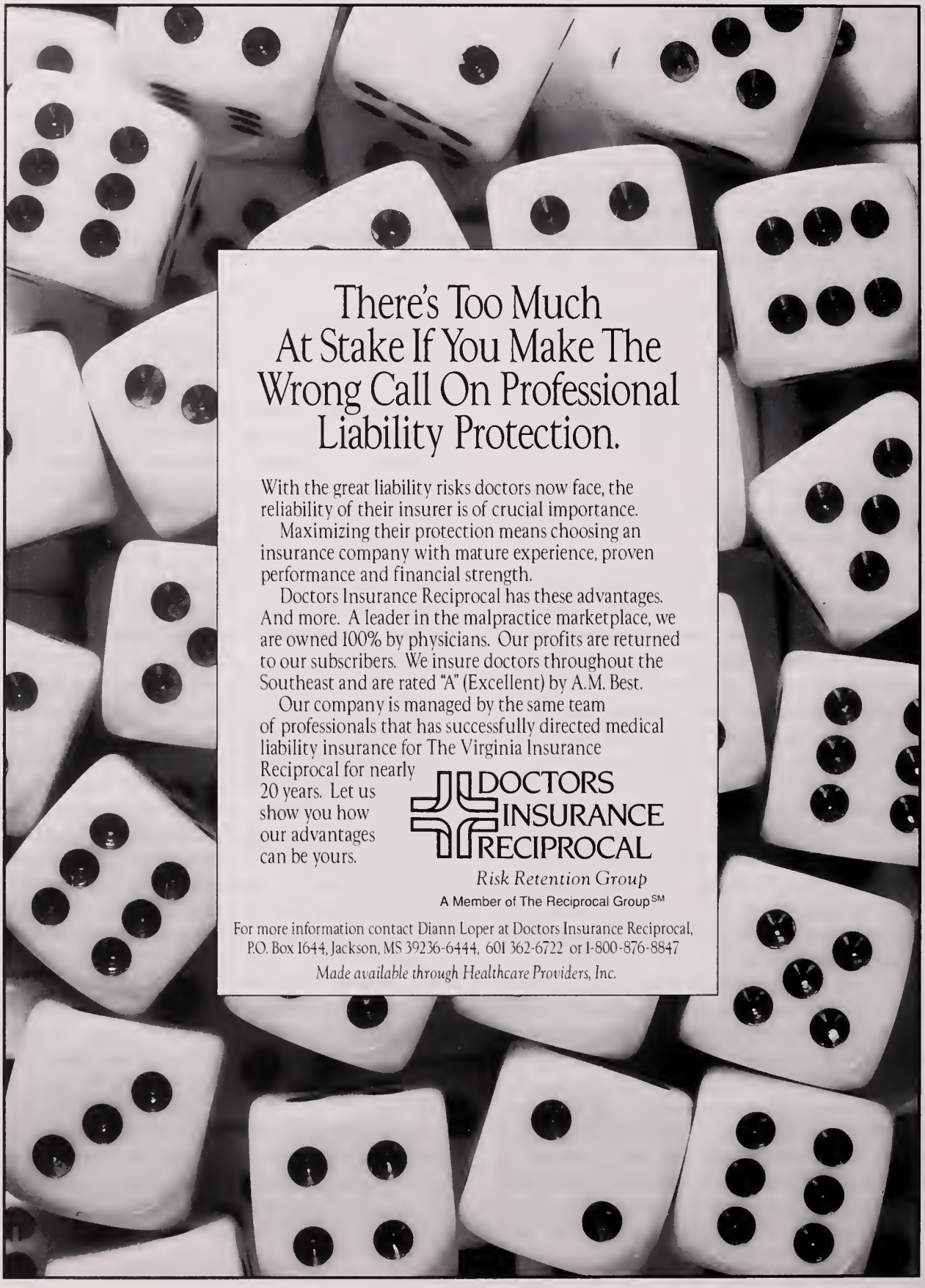
The Complaint: Pain with activity and exquisite tenderness over the lateral epicondyle of the humerus is diagnostic and usually occurs whenever it is accidentally touched or bumped. Gripping hard, sudden jolts, and even shaking hands can be quite painful.

Findings: Point tenderness over the lateral epicondyle or just distal to it, associated with pain on forced flexion of the extended wrist or long finger. X-rays are rarely helpful except in chronic cases where calcifications may be seen.

Pathophysiology: This poorly understood inflammatory condition of the common tendon of origin of the wrist and finger extensors is notorious and can be quite disabling because of pain. Direct trauma is aggravating and greatly increases the symptoms. Actual degeneration of tendon and calcification occur in chronic cases.

Treatment: Conservative treatment is effective in well over 90% of cases. This consists of NSAIDS, an elbow pad to prevent trauma, strengthening exercises with a hand gripper and contrast baths. The second line of defense is direct steroid infiltration to the tissue above the common tendon of origin. Surgery is reserved for those cases where other treatment has failed and consists of removal of the chronically inflamed and damaged tendon. The rehabilitation is slow and surgery should only be undertaken when symptoms cannot be controlled by other means.

Dr. Michael E. Jabaley *is Clinical Professor of Plastic and Orthopaedic Surgery at the University of Mississippi Medical Center and is in private practice for plastic and reconstructive surgery.*



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H. Vann Craig, M.D.

The President's Page

Where Are We Going?

The delivery of Health Care in this country is changing. There is no question about that! The more things change the more they remain the same. Physicians are still responsible for delivery of that Health Care and still responsible to that patient who has come to us with trust that we will CARE for them. The physician - patient relationship may from time to time have third parties - insurance companies, government, or one of the "O's" - placed between the physician and the patient, but that relationship and that responsibility is still there. Like the Hale-Bopp comet on a cloudy evening, it may be obscured but it is still there bright and shining.

At the AMA leadership conference in Philadelphia, Pennsylvania, several speakers addressed the "Future of Health Care Delivery". Physicians have always managed health care. The change that is occurring is the concept of retail versus wholesale. Retail delivers on an individual basis, while wholesale delivers in large numbers. That is HMO's offer patients in large numbers rather than one at a time, as we currently see patients. Physicians are reasonably intelligent individuals. If you tell me what the rules are, I will learn to play your game. Right now in Mississippi we aren't sure what the rules are. We must learn those rules so we can play to benefit our patients. We must change our thinking from retail to wholesale.

Also addressed, was the future of the HMO system. HMO's are the current cause de jour of congress and state legislatures. They are threatened with regulation and restriction. They will probably be relegated to the role of brokers rather than providers of health care. The providers will be groups of physicians who address a specific disease process or type of care and capitate that care to the provider of "insurance" be it industry, government, or groups of individuals. Wholesale thinking.

Physicians will again gain control of our future and like the Hale-Bopp comet our future will be bright for both us and our patients.

That's where I think we are going!

Vann



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Editorial

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So Long to Medicaid Peer Review

By now everyone is aware that the Foundation, for Medical Care in Jackson was not selected by the Mississippi Medicaid Commission to continue to provide peer review services. In late March the Commission accepted the bid of the Louisiana PRO to provide the services that have always been provided by Mississippi doctors through the Foundation.

The Commission has erred. So much did the Foundation want to provide the service that it provided it in the past for a virtually break-even amount of money. That state of affairs was worth the while of the Foundation because it kept the doctors of Mississippi closely involved with Medicaid in more than just a provision of medical care role. Providing peer review placed the doctors in the position of assisting the administration of the program and thus defused a considerable amount of the us versus them mentality that would otherwise rear its head. And it surely will rear its ugly head now.

A doctor performing necessity of admission and length of stay reviews on the part of the Foundation, as I have done on occasion in the past, balances two views. First, knowing the Medicaid program has limited funds, he wants the money to go for care only to those sick enough to need it and for only as long as they need it. It's our, Mississippi's, program. If Medicaid runs out of money, everyone here suffers.

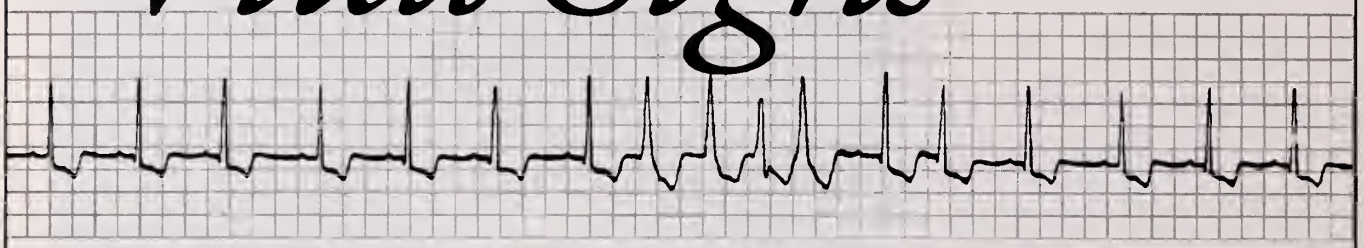
Second, the doctor performing reviews knows he may cross the path one day of the attending physician to whom he is speaking over the telephone That attending might even one day perform the review physician's bypass surgery. Mississippi is a state of small towns. People talk. The word spreads. It pays to be both fair and civil.

Which goes a long way toward stating what is wrong with the Medicaid Commission's decision. What inherent interest will the Louisiana PRO have in seeing that Mississippi has an effective Medicaid program? The Foundation for Medical Care is composed of a large percentage of the physicians in Mississippi. Its administration and board are doctors from every part of the state who are able to explain personally in their communities why things are done as they are. Having the Foundation's cooperation and participation with Medicaid would surely make for a better program.

-Leslie E. England, M.D.
Associate Editor

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Dears Sirs,

I have followed with interest for several years the efforts of the Physician Assistants in Mississippi to obtain enabling legislation to practice in Mississippi. I am very disappointed in the most recent result in the latest, legislative session and especially the tactics used by the Mississippi Nurses Association (MNA) to obstruct a vote on this issue. I have written to the MNA and enclosed a copy of that letter for your perusal. I feel that the MSMA should strongly and actively support this legislation for several reasons.

The PA is a competent well trained mid-level practitioner who is trained in a medical school model and functions utilizing the same methods and problem solving approach utilized by the physician. This practitioner is a "dependent" practitioner who works under the supervision of the physician employer and augments his employer's scope and breadth of practice significantly. By contrast, the Nurse Practitioner claims to work in a "collaborative" status with the physician and maintains she is making nursing diagnoses and prescribing nursing treatments. This is a semantics game that is shallow at best.

The quality of care provided by PAs is well documented over the years and the benefits of utilizing PAs in practices far exceeds any liability risks. I would like to encourage your organization to consider taking a more active and aggressive role in supporting this legislation in the upcoming legislative session in Mississippi.

Thank You very much,

John P. Hartman PA-C
Internal Medicine Group, Cheyenne, WY

To the board of directors of the MNA,

I would like to address the MNA opposition to enabling legislation for Physician Assistant practice in the state of Mississippi. I have followed this issue for the past several 'years and am disappointed in the developments in the latest session of the Mississippi legislature. I am a PA in practice in Cheyenne, WY for nearly twenty-two years now with a multispecialty Internal Medicine group of thirteen physicians. I have filled a number of different niches in this practice including outpatient clinical visits, nursing home rounds, specialized endocrinology testing and most recently I have spent part of my time as Clinical Director for a local health care for the homeless clinic. In this last capacity I share clinician time with a Family Nurse Practitioner from the City/County Health Unit. Her time is an "in kind" service to this federally funded clinic. She covers on Monday mornings and I cover three other mornings, plus volunteer physicians and nurses cover a once a week evening clinic. Linda has clinical expertise in family planning, pediatrics and immunizations and I have expertise in adult medicine areas. We compliment each other very well and together serve the majority of the needs of this population quite well.

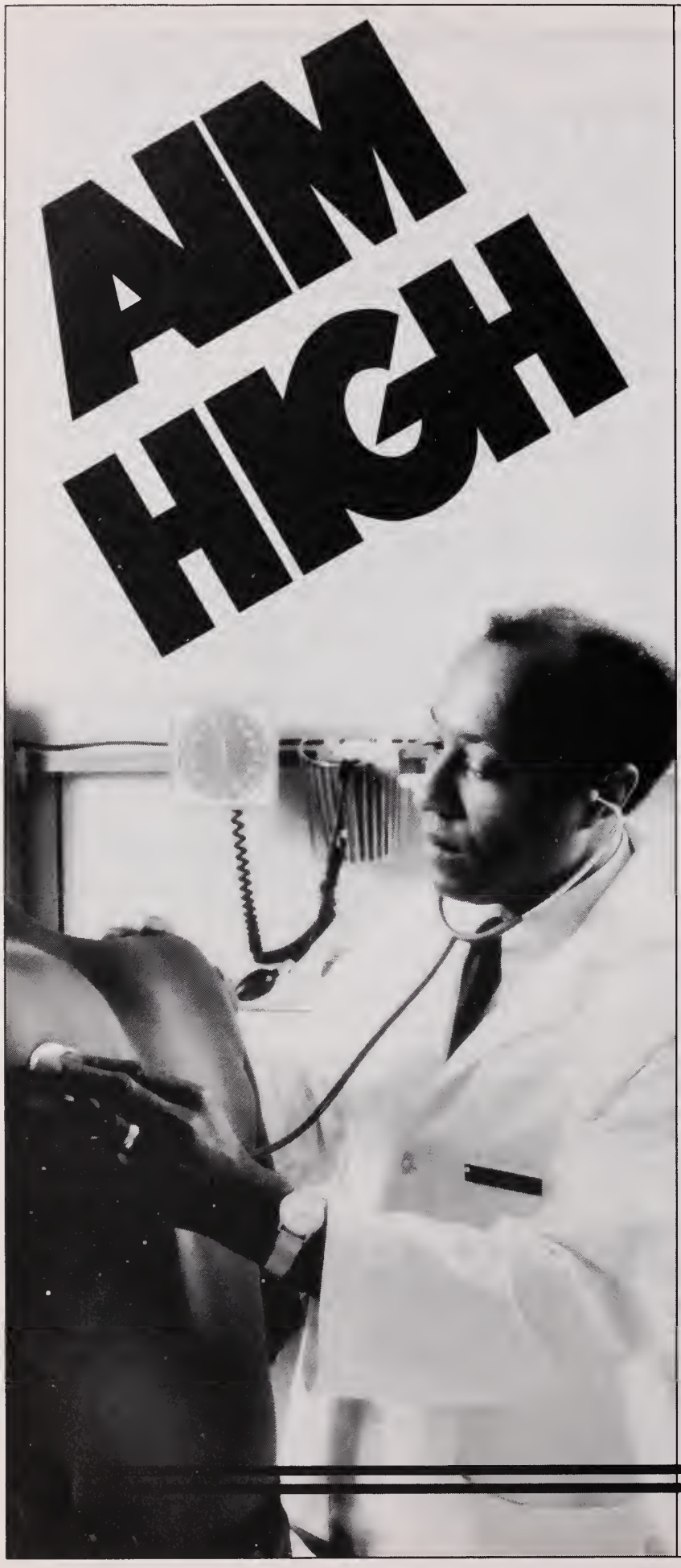
Ninety miles west of me is a small mountain town called Saratoga, WY. This town has a new state of the art rural clinic that offers an impressive array of services to the entire region. Their staffing consists of a physician (family practitioner), a full time PA, one full time NP who provides a large part of the pediatric care, and a part-time family planning NP who comes from another clinic sixty miles away. This arrangement seems to work well for all clinicians involved and especially well for the community and region. I offer these two examples as good representation of how PAs and NPs can complement each other as mid-level practitioners.

I believe that there are some significant populations in Mississippi that are still undeserved and I feel that the MNA obstruction of PA enabling legislation is at worst self-serving and at least ill informed. I don't believe that otherwise well informed, well educated nurses could actually believe that PAs are "high school graduate with only on the job training" who would threaten the health and welfare of the populous of Mississippi. I see this simply as a misinformation campaign in a effort to obstruct reasonable legislation. I hold two bachelor degrees, one in Psychology and one in Medicine plus a certificate as a surgical technician. I am representative of the majority of PAs in the country who come into the profession with other health care experience and often holding degrees from related fields. I find it offensive that you felt obligated to try to dictate what credential the PAs in Mississippi should hold before practicing in that state. By far more important would be whether they had graduated from an accredited program and passed the national certifying boards exam for Physician Assistants (NCCPA).

There are a lot of people following this issue around the country at all levels, not just PAs. By continuing this tact you only embarrass yourselves. I would hope you could find a common ground with the MAPA and the MSMA before the next legislative session. This can only benefit the people of Mississippi in the end.

Thank you for your consideration,

John P. Hartman PA-C



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AIR FORCE

Physician's Recognition Award (PRA) Certificates Up 11% - Online Application, Reciprocity Agreements Pay Off in 1996

The American Medical Association's (AMA) Physician's Recognition Award (PRA) is the most widely accepted standard for recognizing physician completion of continuing medical education (CME). Over 640,000 certificates have been issued since the PRA's founding in 1968, making the PRA the most frequently sought of all CME certificates. In 1996, issuance of PRA certificates increased 11%, due to the availability of a new online application and reciprocal arrangements with state and specialty medical societies—making the application process quicker and easier.

The AMA is using the power and popularity of its World Wide Web home page to promote the PRA. An electronic PRA application is now available (select http://www.ama-assn.org and proceed to the "Medical Science and Education" section). In addition, the new online Physician Select database, which lists all U.S. physicians, now includes text noting whether a physician holds the PRA certificate.

"The double-digit increase in PRA certificates is ample evidence of the reborn interest in and appreciation of the PRA among physicians," said Michael J. Scotti, Jr, MD, vice president, Medical Education. "Today's increased emphasis on accountability in health care delivery has increased the value of holding the certificate."

The AMA will continue to build on the 1996 growth by developing an online copy of the PRA handbook and using the PRA as a credential indicating CME participation in the AMA's newly launched American Medical Accreditation Program. Known as AMAP, this ambitious project seeks to provide the first comprehensive accreditation process for physicians.

To receive more information or a PRA application, call 312-464-4665. A fax application is available by calling 800-621-8335 and pressing 2.

Medical Association Develops Physician Relief Program for Grand Forks

The North Dakota Medical Association announced a statewide effort to provide physician relief services to assist in the early reconstruction effort in Grand Forks.

Robert Grossman, M.D., President of the Association explained the program. "When the residents of Grand Forks and other communities along the Red River are allowed to return to their homes, we must be prepared to provide necessary medical care. Most local physicians will be returning to damaged homes, and will certainly want to assist their families and friends in the clean-up effort. We are asking other physicians across the state to help out during this most difficult transition period by providing their on-site medical expertise.

Physicians in any specialty wishing to volunteer their services during the upcoming weeks of restoration are asked to call 701-223-9475 or1-800-732-9477 to register with the Association. All services, regardless of duration, would be greatly appreciated.

Cathy Rydell, Executive Director of the Association has contacted other State Medical Associations requesting out-of-state physician volunteers to assist in the effort as well. "The response has been very gratifying. We are confident we will be able to help staff the medical facilities with fully qualified physicians."

Once local authorities have approved the return of Grand Forks residents to their homes, the North Dakota Medical Association will coordinate the physician relief effort with the local medical community. Volunteers on the roster will be contacted to arrange specific times and locations for providing support and care to citizens in the Grand Forks area.

Dr. Casey Ryan, President of the AT-TRU Health Systems (United Hospital-Grand Forks Clinic) expressed his gratitude. "We are so thankful for the compassion and generosity of our fellow physicians. Together we will assure the health care needs of the people of the region will continue to be met during these difficult times."

Vocational Rehabilitation Center Changes Name to T.K. Martin Center for Technology and Disability

Ceremonies were held recently to dedicate the T. K. Martin Center for Technology and Disability at Mississippi State University. The Mission of the T.K. Martin Center is to maintain a state-of-the-art clinical, research and training facility for the purpose of improving the functional capabilities of Mississippians with disabilities through appropriate applications of Assistive Technology.

The T.K. Martin Center is unique in the field of Assistive Technology because it is a direct clinical service center located on the campus of a major research university. The benefits of this combination allows for integration of Assistive Technology issues into multiple areas of academic study and promotes the interdisciplinary research which is so crucial when applying Assistive Technology to the needs of persons with disabilities.

The T.K. Martin Center is a consumer oriented organization, designed to meet the special needs of individuals with disabilities while they are involved in a service delivery program of Assistive Technology. It provides services to individuals with severe disabilities whose functional limitations affect communication, vision, motor skills, or cognition.

The services of the T.K. Martin Center are not directed at specific disabilities and diagnosis, but are addressed towards the functional limitations experienced by persons with any type of impairment which results in a handicap and creates barriers to the completion of essential tasks.

The following services are available through the T.K. Martin Center:

- Adaptive Computer Access
- Home Accommodations
- Augmentative and Alternative Communication
- Job Accommodations
- Adaptive Driving Seating and Mobility
- Assistive Technology for Visual Impairments
- Assistive Technology for Brain Trauma
- Assistive Technology for Hearing Impairments
- Assistive Technology for Learning Disabilities

The T.K. Martin Center is equipped with state-of-the-art adaptive computer laboratories, design and fabrication shops, a vehicle augmentation lab, a seating and mobility center, and specialized examination and evaluation rooms. The T.K. Martin Center is staffed by a team of rehabilitation engineers, therapists, and associated staff.

The T.K. Martin Center can receive referrals from a variety of sources, including:

- Mississippi Department of Rehabilitation Services
- Mississippi Department of Health, Early Intervention
- Private Insurance Companies
- Mississippi Department of Education
- Workers Compensation Commission
- Private Rehabilitation Companies
- Hospitals
- Home Health Agencies
- Special Education

To make a referral to the T.K. Martin Center, or for additional information, please contact:

T.K. Martin Center for Technology & Disability
P.O. Box 9736
Mississippi State University
Mississippi State, MS 39762
Phone: 601-325-1028
Fax: 601-325-0896
TDD: 601-325-0520

NATIONAL HIV TELEPHONE CONSULTATION SERVICE "Warmline" (800-933-3413)

Based at San Francisco General Hospital, the "Warmline" provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists, and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 am and 5:00 pm PST. A twenty-four hour voice mail system is available at other times. The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers, and the American Academy of Family Physicians.

Call for Photographs by Mississippi Physicians

We want your best shots. Photo shots that is. The *JOURNAL MSMA* is seeking outstanding photographs taken by physicians for publication on the cover of 1998 issues of the magazine. We are searching for exceptional photographs taken by Mississippi physicians. The subject matter can be landscapes, people, sports, animals, or anything else that physicians have captured on film. The Committe on Publications will judge the entries on the merits of quality, composition, originality and appropriateness to the *JOURNAL MSMA* and select the top twelve best photos to appear on the cover. Photographs must be submitted by October 1, 1997 to be considered.Color photos will be accepted. Print size must be approximately 5 by 7 inches or 8 by 10 inches. Vertical format photos are preferred; however, some horizontal format photos can be cropped to fit.

Send entries along with a brief description of the subject, as well of yourself, to Karen Evers, managing editor, JOURNAL MSMA, Mississippi Medical Association, 735 Riverside Drive, Jackson, Mississippi, 39202. For more information, contact Ms. Evers at (800) 898-0251, extension 412, or (601) 354-5433.

Equipment Sought for Medical Mission

A Jackson based medical mission organization is in the process of establishing the first American standard hospital in the east African country of Malaivi and seeks used medical equipment in good working condition for that purpose. Any items essential to the establishment of a new hospital are acceptable and all donations are tax deductible. For questions and pick-up arrangements call Dr. Jack Flood (601-981-0926) or Paul Chinchen (601-925-0512). Malaivi has a physician population ratio of 4:100,000 and an infant mortality rate of 143:1,000. Health education will also be an important component of the new hospital's services. There will be two educational programs implemented. The mobile clinic services of the hospital will be utilized to hold classes on nutrition, hygiene and preventive medicine targeted particularly on child care. The clinic's staff will also offer on-site classes leading to a premedicine certificate.

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The University of Mississippi School of Medicine held its Honors Day ceremony Tuesday, May 6, 1997. The recipient of the Virginia Stansel Tolbert Award was ***Dena W. Jackson*** *of Brookhaven. The cash prize and plaque are given to a medical student who has demonstrated superior scholarship and leadership in campus activities. Additionally, the recipient must exhibit interest in issues which affect the profession and willingness to devote time and effort to those matters. Right:* ***MSMA President Dr. Fred McMillan.***



The Carl Gustav Evers Award was presented to ***Meredith M. Travelstead*** *of Jackson. Established by the MSMA Foundation in memory of Dr. Carl G. Evers, professor of pathology and associate dean for academic affairs, who died November 19, 1992, this award consists of a plaque and a cash prize. The award is given to a senior medical student who has demonstrated qualities of scholarship, peer to peer support, and exceptional leadership in student activities of the AMA and the MSMA. Left:* ***Mrs. Carl G. (Jan) Evers.*** *Right:* ***MSMA President Dr. Fred McMillan.***



Mississippi Governor Kirk Fordice *(seated) pens his signature to SB 2589, the off-label cancer drug bill, at a ceremony in his State Capitol office. Pictured with him are supporters of the bill. They are (left to right)* ***Adriane Spencer,*** *State Government Affairs Manager for Zeneca Pharmaceuticals; Senate Insurance Committee Chairman* ***Dean Kirby*** *of Pearl;* ***Ralph B. Vance, MD,*** *UMC Professor of Medicine;* ***Fred G. Wiseman,*** *Associate Director for Bristol-Myers Squibb;* ***Debbie Hays,*** *Government Programs Manager for Rhone-Poulenc Rorer;* ***Karen S. Gillespie,*** *Government Affairs Manager for Bristol-Myers Squibb Company; House Insurance Committee Vice Chairman* ***Keith Montgomery*** *of Clinton; and,* ***Van L. Lackey, MD,*** *President of the Mississippi Society of Oncology.*

MSMA Alliance Emeritus Tea

The Emeritus Alliance members of the Central Medical Society gathered for a tea March 20, 1997 at the home of Mrs. Carl G. (Jan) Evers. Shown below are the hostesses of the tea and the Central Medical Society Alliance officers.



Hostesses (left to right) Trudy Lipscomb, Rachel Aultman, Celeste Hutchinson, Willie Sneed, Jan Evers, Jane Ladner and Martha Smith.



Central Medical Society Officers (left to right) Trudy Lipscomb, Martha Smith, Angela Byers, Sharon Guild, and Rachel Aultman.



Carolyn Chustz and Paula St. Claire



Kathryn Wiener and Marnee Bell



Jan Purvis, Rachel Aultman and Marnee Bell



Trudy Lipscomb and Ruth Smith



Rachel Aultman and Ann Imrie



Betty McCay, Jan Evers and Marnee Bell

Analyses

The Foundation for Medical Care's Emergency Room-Acute Myocardial Infarction Project (ER-AMI) represents a new Health Care Quality Improvement effort which resulted from the Cooperative Cardiovascular Project (CCP), the Health Care Financing Administration's first national endeavor.

The Foundation began participating in the Cooperative Cardiovascular Project in 1995, and the results have been significant. The project, which involved larger hospitals in the state, led to the Foundation's recognition of the need to identify early treatment interventions undertaken in small hospitals. The smaller hospitals often transfer patients from their emergency rooms to larger facilities rather than admitting them. Twenty-three smaller facilities have expressed an interest in improving their processes involving the use and timing of thrombolytics and the use of aspirin while patients are in the emergency room.

The Emergency Room Acute Myocardial Infarction (ER-AMI) project includes the following goals: increasing knowledge and utilization of the current guidelines; improving the processes and outcomes of care for patients with an AMI; improving delivery of those interventions that have been clearly proven to decrease morbidity and mortality; and demonstrating that small hospitals can effectively improve care through participation in quality improvement projects.

The initial data collection will be performed by the clinical data abstraction center, DynKePRO, and the data will be abstracted from hospital emergency room and inpatient records with a diagnosis of AMI from Jan. 1 through Dec. 31, 1996. The data will then come to the Foundation for analysis. While the primary focus is on emergency room/outpatient records, inpatient charts will be included when patients were admitted at the smaller facilities.

The ER-AMI project is one of the first outpatient projects undertaken by the Foundation. Its importance is reflected in the fact that AMIs were the second leading cause of admission to hospitals for the country's 35.6 million Medicare beneficiaries in 1992. AMI was also the cause of 2.8 percent of all Medicare short-stay hospitalizations. Average hospitalization cost for AMIs is $11,650, while admissions for all AMIs accounted for 15 percent of all Medicare expenditures for short-stay hospitalizations.

Update on CCP

As of March 1997, through onsite or regional presentations, hospital-specific Cooperative Cardiovascular Project data have been provided to the appropriate hospitals. Forty-three hospitals have submitted improvement plans to the Foundation with 33 completed.

Internal follow-up data have been received from 17 of these hospitals. Ten hospitals have noted improvement in at least one indicator.

DyneKePRO, the central data abstraction center, is currently requesting charts from the hospitals who have completed their improvement plans. Data will be sent to the Foundation and presented to collaborating hospitals after analysis is completed.

For further information on the CCP and ER-AMI projects, contact project manager Sherry Hill, RN, at 948-8894.

-James S. McIlwain, M.D.
Principal Clinical Coordinator

The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the state of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this article does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care

Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.



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New Batson Hospital Reflects Changes in Pediatrics

Probably no medical specialty has changed as much as pediatrics in the past 30 years. And those changes, according to pediatrics department chair Dr. Owen B. Evans, have made dramatic differences in the lives of children.

Patients with childhood cancer are often cured. New medications and antibiotics make the lives of cystic fibrosis patients infinitely better.. and longer. Pediatric neurology didn't even exist before the 1960s.

If there is a flip side to this happy situation, it is that children have longer and more frequent hospital stays, and the changes in the specialty have put increased demands on the physical facilities to keep pace.

The Blair E. Batson Hospital for Children, which will be formally dedicated in a ceremony on May 16, is Mississippi's answer to that challenge.

Named for the man who first chaired the Department of Pediatrics at UMC from 1955 until he retired in 1988,the new hospital is designed and equipped to accommodate all that medicine knows about helping sick children and to make their families as comfortable as they can be when a child is ill.

When the existing children's hospital opened in 1968, it was designed for the needs of hospitalized children at the time. The small rooms weren't designed for the monitors and specialized equipment used today. Nor were they designed for extended stays. The logistics for isolation were not considered because there was little need. AIDS did not exist, and neither did cancer survivors with medically suppressed immune systems.

By contrast, the new hospital will have rooms with separate airflow and ventilation to control the spread of infectious organisms. The isolation rooms will also make pediatric bone marrow transplants possible.

Included in the 130-bed hospital are areas for physical therapy, infant care, special treatment rooms, a pediatric pharmacy, and rooms especially designed for the disabled.

A much larger intensive care unit in the new hospital is designed with parents in mind. A new PICU step down unit is for those patients who no longer need the level of care provided in intensive care but who are not yet ready to be moved to a room.

Each of the rooms in the hospital has its own bathroom, is large enough to house a visiting parent comfortably, and is equipped for all the monitors and machines that are often necessary. They are also large enough to allow easy access during emergencies.

The $17 million building is five floors above the Mississippi Children's Cancer Clinic. The first floor houses infant care, PICU and the PICU step-down unit. Second floor rooms are for pediatric surgery cases. Third floor occupants will be primarily oncology and hematology patients. Medicine patients will occupy the fourth floor, and the fifth floor is reserved for adolescents-complete with a teen activity room.

Each of the floors except the first has its own playroom and classroom. Thirty years ago, we didn't know as much

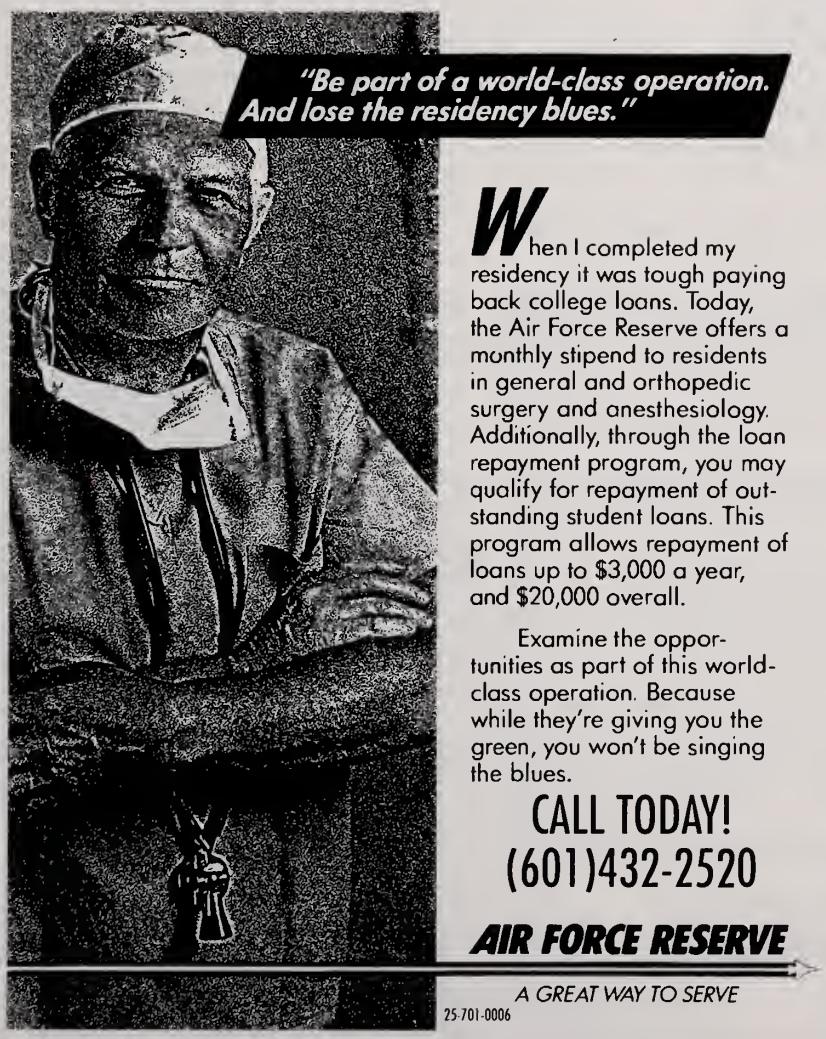
about childhood development as we do today," Evans said. "A child who is hospitalized for an extended period just can't stay in bed all day."

The man whose name will grace the new building oversaw most of the changes Evans talks about. He began the practice of pediatrics when infectious diseases were diagnosed by clinical presentation rather than a battery of sophisticated laboratory tests. The first five years he was chairman, his staff treated diphtheria, roundworm, measles (with complications), even polio-diseases that have all but disappeared.

It was Batson who lobbied for the first children's hospital-at a time when the most pressing need was for more hospital beds for pediatric patients. Batson had a simple message: "Children aren't miniature adults. They have different needs and need a different kind of hospital."

Naming the hospital for Batson honors not just his direct contribution to the health of children, but his role in teaching the pediatricians of Mississippi. He has taught more than 3,500 medical students and trained 240 residents. One of his former residents, Dr. Paul Welch, now in private practice in Jackson, calls Batson the "grandfather of pediatrics in Mississippi."

"Naming the new hospital for him is a tribute to a real hero."



Paul M. Allen, M.D., an obstetrician/gynecologist practicing in Pascagoula, has contributed a chapter on Accreditation, Risk Management, and Reimbursement, to a textbook entitled *Outpatient Gynecologic Surgery*, which has recently been published by Williams & Williams. Dr. Allen was one of three authors to contribute new chapters to the third edition of this text, which advises physicians on how to bring their practice up-to-date by providing their patients with safe, effective, and innovative gynecologic surgery in the outpatient setting of office or free standing surgery centers. Dr. Allen is the Medical Director at Women's Center for Health Care and also serves as Chief of the Medical Staff at Singing River Hospital in Pascagoula.

Leonard H. Brandon M.D., of Starkville, MS, has completed continuing medical education requirements to retain Active membership in the American Academy of Family Physicians (AAFP), the national association of family doctors. Dr. Brandon has been an Active AAFP member since 1969.

S. H. Subramony, M.D. is listed among "America's Best Doctors" in a prestigious nationwide guide. He is listed for his expertise in neurological surgery in the guide that is annually prepared by Worldwide Medical Information Services and published by Woodward/White Inc. Doctors qualify for inclusion in the guide based on survey responses by some 35,000 physicians. These physicians were asked to rank the clinical abilities of their peers by answering the following: "If a friend or loved one came to you with a medical problem in your fieid of expertise, and for some reason you could not handle the case, to whom would you send them?" The guide is used by insurance, research and pharmaceutical companies, hospitals, HMOs, and patients in choosing and affiliating with doctors.

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Attention: MSMA Members

The **JOURNAL MSMA** is seeking manuscripts that have not been previously published and are not under consideration by any other publication, submitted in accordance with the guidelines for authors. Articles of medical, socio-economic nature as well as articles of local appeal relative to medical practice in Mississippi are of particular interest. Manuscripts are subject to the reviewing process by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to **JOURNAL MSMA** readers, and usefulness or importance to physicians. Authors are notified upon acceptance or rejection of their manuscript. Contact the managing editor with any questions concerning submission guidelines. Address all correspondence to the Editor, **JOURNAL MSMA**, P.O. Box 5229, Jackson, MS 39296-5229. Phone:(601)354-5433, extension 412.

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Baptist Memorial Hospital-North Mississippi is a 158-bed rural referral center and has been noted as one of Mississippi's fastest growing hospitals. Having recently completed a $25 million construction project, the hospital is breaking ground on a new project which will include: Physician Office building expansion, development of a Heart Care Center, Cancer Center, and a Wellness Facility. Currently, the facility houses a Women's Pavilion and a Pediatric Unit.

The Family Practice opportunities are located in Oxford and nearby Pontotoc. Join a two-physician group in Oxford with special interest in allergy and industrial medicine. The clinic is new construction with dedicated laboratory and x- ray. Another opportunity in nearby Pontotoc provides a new 6,000 square foot clinic with dedicated laboratory and x-ray in a growing medical community. Both opportunities provide excellent benefits and pay with the option of income guarantee or salaried positions. **Call Peyton Warrington at 1-800-264-8104 for more information on this and other opportunities.**

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Position Announcement
Staff Physician

Mississippi State University Student Health Services, accredited by the Accreditation Association for Ambulatory Healthcare, requests applications for the position of Staff Physician. This is a full-time, twelve-month position. Its function is to provide primary medical care to students, faculty and staff, and others at the John C. Longest Student Health Center. This position requires an M.D. or D.O. degree, board certification or board eligibility in a primary care field, and a valid license or license eligibility to practice medicine in the State of Mississippi.

Mississippi State University is a land-grant institution located in Starkville, Mississippi with a student enrollment of over 14,000. The total income package is competitive with office-based primary care physicians, with one-in-four light rotating call. The University offers excellent benefits including health and liability insurance, CME allowance, and retirement plan.

The position is available on July 1, 1997 or as agreed to by applicant and the Director. Applications will be accepted until the position is filled. Send applications that include: a letter of interest, a current CV, and at least three references to: Chair of Physician Search Committee, Box 9732, Mississippi State, MS 39762. MSU is an AA/EEO employer.

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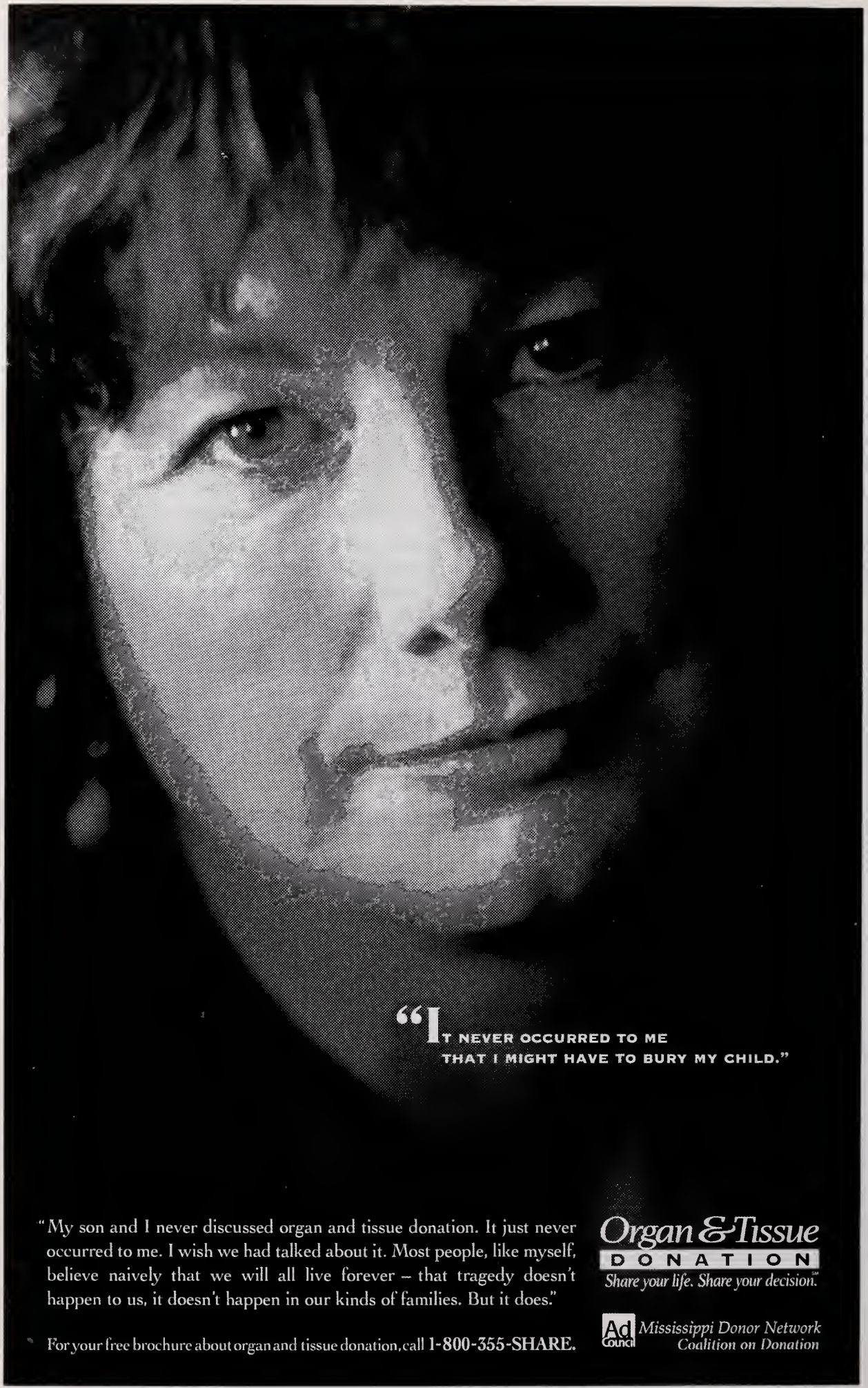
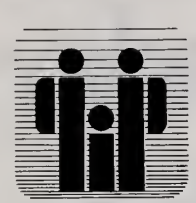


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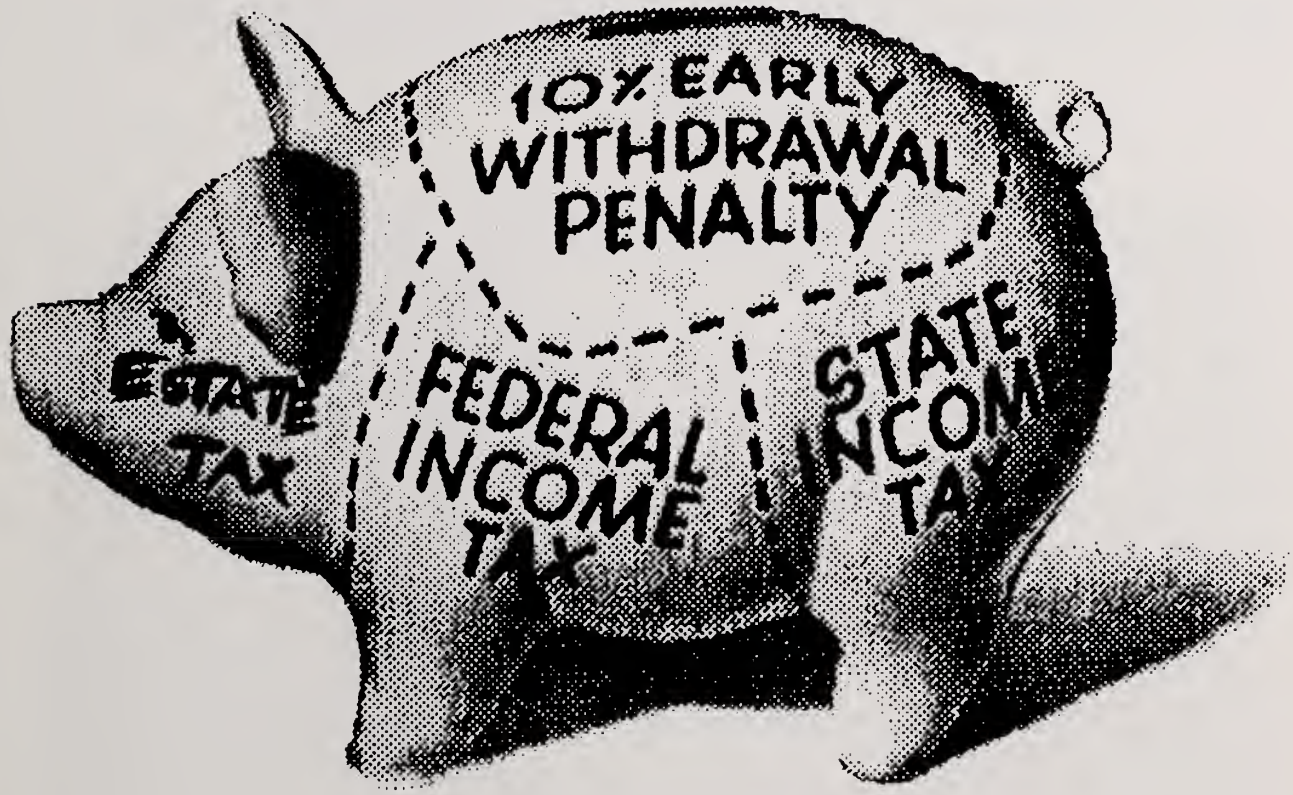
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"The most important thing a physician can do when preparing to sign a contract with a hospital or managed care organization is to sit down...turn the TV off...and take time to read the contract," Hill said.

Some items which warrant special attention, according to Dr. Hill, include:

- Gag Clause: Never agree to sign a contract which contains a gag clause -- doing so takes away your right to be open with your patients regarding policies.
- Access to Other Physicians: Never sign a contract which contains a provision that requires you to use only in-panel physicians without some mechanism for using someone outside the panel when you feel it is necessary.
- Hold Harmless Clause: An exclusive hold harmless clause is not in the best interest of the physician or the corporation. Both have exposure, and both are responsible for patients. No one should be held responsible for the actions of the other party.

Hospitals are purchasing physician's practices -- and purchasing their malpractice coverage through the hospital's insurance company.

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Brain Metastases From Unknown Primary Site

T. Khansur, M.D.[1]
A. Routh, M.D.[2]
B. Hickman, M.D.[3]

ABSTRACT

We report our experience with 32 patients presenting with brain metastasis from unknown origin. This constitutes 11.5 percent of 276 consecutive patients with brain metastasis seen over a period of eight years at the University of Mississippi Medical Center. Patients with solitary resectable lesion underwent surgery followed by irradiation. All patients with multiple metastasis were treated with whole brain radiation and dexarnethasone. The mean survival was 31.50 weeks for patients with single lesion and 19.11 weeks for multiple lesions. The investigations and treatment management of brain metastasis from unknown primary site are discussed.

Key Words: Brain Metastasis, Cancer unknown Primary, Radiotherapy.

Brain metastasis causes major morbidity to patients suffering from malignant disease. Unfortunately, the incidence of brain metastases is increasing as the incidence of malignant disease is increasing. According to American Cancer Society, in 1981, there were 815,000 new cases of cancer diagnosed.[1] In 1994 there were 1,208,000 new cases diagnosed.[2] In 13 years there was a 148% increase in the number of new cases of malignant disease. Moreover, patients with malignant disease are living longer due to improvement of treatment. In a previous report, we reported the results of the treatment of brain metastases in patients in our institution.[3] The patients were treated during the period of 1982-89. We now report the results of treatment of brain metastases to a special group of patients in whom we never found the site of primary neoplasm at the time of treatment.

Materials and Methods

The records of all patients who underwent treatment for brain metastases in the period of 1982-1989 were reviewed. A total of 276 patients were treated during that period. The lung carcinoma was the most common source of brain metastases. The lung carcinoma was the primary site in 57% of the patients followed by breast carcinoma in 11.57% of the patients. Primary source of neoplasm was not found in 32 cases (11.59%). Four special cases were included in this series. These patients had multiple neoplasms. One patient had two neoplasms and the other three had three neoplasms. Any of the neoplasms could be the primary source of metastases in brain. Five patients had suspicious chest x-rays but further investigations did not reveal any neoplasm.

Histological diagnoses were obtained by craniotomy in many cases. In patients with solitary metastases, resections were performed. In deep seated tumors, stereotactic biopsies were obtained. All patients who had abnormal chest x-rays underwent computed tomography of chest and abdomen. If there were occult blood in stool, then various gastrointestinal investigations were performed to exclude primary neoplasm. Serum prostate-specific antigens (PSA) tests were performed in male patients.

If, after all these tests, no primary site was found, then patients were grouped in this group -- Patients with unknown primary site. Details of all these patients are listed in Appendix A.

Patient Characteristics

Mean ages of patients were 56.6 years. The age ranged from 35 years to 74 years. There were 16 Caucasian patients, 15 African-American patients and one American-Indian patient. There were 24 male patients and 8 female patients.

Presenting Symptoms

All patients presented with neurological symptoms. Headache (40.62%) was the most common symptom followed by paresis (21.87%) and seizures (15.62%). The other presenting symptoms and signs were weight loss in 4 patients, syncope in one patient, hallucinations in one patient and dementia in one patient.

Metastatic Sites

There were 14 patients who had solitary metastases. Eighteen patients had multiple metastases. Solitary metastases were most common in the parietal lobe in this series. Six patients had metastases in parietal lobes. Three patients had metastases in temporal lobe. Three patients had metastases in cerebellum. Occipital lobe and cavernous sinus were the sites of metastases in one patient each.

Histology

Metastases were confirmed in 25 patients by biopsy. Eighteen patients had craniotomy. Three patients had biopsy of supraclavicular fossa. Biopsy sites of 4 patients were not mentioned. Seven patients were diagnosed radiographically.

Extracranial Disease

Six patients had evidence of extracranial disease at the time of diagnosis.

Treatment

All patients received palliative radiation therapy treatment. Radiation doses ranged from 3,000 cGy in 10 to 15 fractions to 5,400 cGy in 30 fractions. Two patients also received chemotherapy treatment.

Survival

All patients have expired. The mean survival time for patients with single brain metastases was 31.50 weeks compared to 19.11 weeks for patients with multiple brain metastases. Six patients died during or immediately after treatment.

Metastases

Three patients developed further metastases before death. One patient developed metastases to lung and bone. One patient developed metastases to bone and another patient developed metastases to the liver.

Recurrence

One patient developed multiple brain metastases and another showed progression of disease after radiation therapy treatment. One patient developed recurrences after eight months and underwent surgery. He then received another 1,400 cGy to the brain.

Manifestations of Primary Tumor

In some reports [4,5] primary sites of malignancy were found in large number of cases. Primary site was discovered in 84% of patients in a series of 56 patients reported by Merchut[6] and in 63% of patients in a series reported by Debevec[7]. In our series, primary site was found in only one patient afterwards. Primary site was found in the lung of this patient. Patient underwent surgery. We cannot explain why we have such a low incidence of the manifestations of primary site.

Discussion

There may be 170,000 new cases of brain metastasis per year.[8] The spread of metastasis to the brain occurs by hematogenous route. Metastasis are generally found in the area directly beneath the gray white junction.[9] Parietal metastasis may be greater in number because of the greater area supplied by middle cerebral artery.[10,11]

Patients with brain metastasis from unknown primary site may be a unique group. Many of the patients may not develop manifestations of primary site during their remaining life period. Primary site may never be found even after autopsy in many cases.[12] In our series of 32 patients, only one patient developed manifestation of primary tumor.

During the search for a primary site of malignancy,

Appendix A

Pt. #	Name	Single or Multiple	Sites of Single Metastases	Other Metastases at time of Diagnosis	Dose in cGy	Dead	Alive in Months
1	FD	Single	Lt. Temp.	None	3000	Dead	4
2	JE	Single	Rt. Parietal	Bone Scan +ve	3600	Dead	24
3	ED	Single	Cavernous	Yes	3000	Dead	1
4	MB	Single	Rt. Parietal	None	5040	Dead	2
5	CD	Single	Post. Fossa	None	3000	Dead	8
6	MD	Single	Rt. Parietal	None	5400	Dead	14
7	WCH	Single	Lt. Parietal	None	3000	Dead	5
8	MJ	Single	Rt. Ocip.-temporal	None	3000	Dead	5
9	PJ	Single	Post. Fossa	Pt. Had GGL	3420	Dead	7
10	MJO	Single	Rt. Temp.	None	3000	Dead	3
11	OL	Single	Cerebellum	None	5040	Dead	4
12	CM	Single	Lt. Parietal	None	3600	Dead	1
13	JP	Single	Lt. Parietal	Liver	3000	Dead	18

14	EEW	Single	Occipital	None	3000	Dead	11
15	AT	Multiple		None	3000	Dead	11
16	MC	Multiple		None	5400	Dead	8
17	KD	Multiple		Liver, Spine	5040	Dead	1
18	UF	Multiple		Mult. Skin	3000	Dead	3
19	OG	Multiple		None	5040	Dead	5
20	RA	Multiple		None	3000	Dead	1
21	WC	Multiple		None	3000	Dead	7
22	WD	Multiple		None	3000	Dead	9
23	JED	Multiple		None	5400	Dead	3
24	RF	Multiple		None	3000	Dead	7
25	GG	Multiple		None	3000	Dead	1
26	LL	Multiple		None	3000	Dead	10
27	CL	Multiple		None	5400	Dead	9
28	GM	Multiple		None	3000	Dead	2
29	SR	Multiple		Lt. SCF	5040	Dead	2
30	TM	Multiple		None	3000	Dead	4
31	MS	Multiple		None	3100	Dead	1
32	EWI	Multiple		None	5000	Dead	2

One should not invest an exorbitant amount of time and money to find the site of the primary. We followed the recommendation of Abbruzzese regarding investigations to be performed to find the primary site.[13] A thorough history and physical examinations should include breast palpation and pelvic examination in females and examination of testis and prostate in male patients. All positive findings in initial evaluation should be investigated fully. Laboratory studies should include hemogram, liver and renal function tests. Radiological imaging studies should include chest x-ray, CT of abdomen and pelvis and mammography in women. In case of gastrointestinal symptoms or in presence of occult blood in stools, thorough investigations of gastrointestinal tract should be performed. In male patients PSA tests should be performed to exclude prostate carcinoma. At the present moment the best non-invasive procedure for diagnosis of brain metastasis is Magnetic Resonance Imaging. In case of solitary metastasis, craniotomy may be performed to remove the tumor, if possible, or to obtain biopsy to exclude other possibilities, i.e., cerebral abscess, infarct or primary brain tumor. In inaccessible sites, stereotactic biopsies can be performed.

Treatment of brain metastasis with unknown primary is mainly Palliative until now. In patients with good Kamofsky Performance Status and solitary metastasis, surgery followed by radiation therapy treatment is superior to treatment only by radiation therapy treatment.[14] In patients with multiple brain metastasis, whole brain radiation therapy is the treatment of choice.[15,16] During the last few years, stereotactic radiosurgery has become one of the methods of treatment of brain metastasis. In an editorial,[17] Dr. Sperduto advocated stereotactic radiosurgery in patients with a solitary metastasis provided patient has adequate performance status, (Kamofsky Performance Status) and systemic disease is controlled. Chemotherapy treatment can cause regression in brain metastasis in chemosensitive histology.[18]

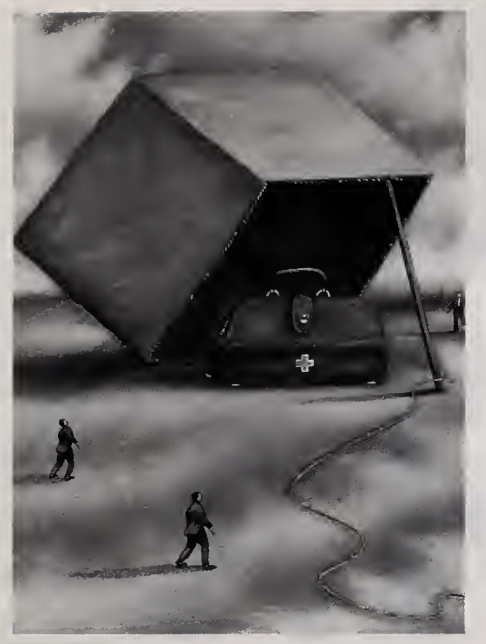
In conclusion, we should not take a nihilistic outlook in patients with brain metastasis with unknown primary. With proper management, the quality of life of these patients can be improved considerably. Salvati reported improvement in Kamofsky Performance Status in many patients after treatment.[19] With aggressive treatment, it may be possible to cure a few patients. Only a prospective trial can settle the argument whether aggressive treatment will be helpful. Hopefully, with aggressive treatment we will be able to cure a few patients in the future.

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George Dale

Thank you for inviting me here today to speak to you on a topic that is of tremendous importance to me as a regulator responsible for advancing the interests of Mississippi's citizens and you as front line providers of health care services to these citizens. Today, I want to address the managed health care revolution in our state, and how it has evolved in Mississippi during the past few years. I would also like to tell you of my hopes that, as managed care continues to evolve in Mississippi over the next few years, competing groups such as the medical community and managed care plan providers and the insurance industry should begin an ongoing dialogue on issues that are bound to crop up as managed care continues to emerge in Mississippi.

With a topic as important as managed care is to both the provider and consumer, I think it is perhaps best to begin by giving you some idea of where I stand on these issues. Caught between the proverbial insurance rock and medical hard place pretty much sums it up. As the state's chief regulator responsible for creating as level a playing field, I want to be sure we get input from all of the parties affected by major policy decisions in these areas so that they can be considered before the climate becomes so polarized that important points of view are lost.

By definition, managed care is just what it says it is: Each patient's care is "managed", usually by one doctor who coordinates a patient's care with the goal of eliminating procedures that are considered unnecessary and emphasizing prevention. This is supposed to make health care more affordable, while, it is hoped, making people healthier.

In the old fee-for-service system, patients were reimbursed through health insurance for each doctor visit and service provided. Patients could visit as many physicians and specialists as they wanted, and they did - as long as somebody else was paying for it. Everybody became spoiled! The old fee-for-service system made health care a huge industry and a major source of employment, investment, and profit in the American economy, but it was also responsible for a huge increase in spending by business and government during the 1970s, 1980s and 1990s. About five or six years ago, everybody seemed to come to an agreement that these cost increases could not continue to escalate — or everyone was going to be broke.

In the late 1980s and early 1990s, the health insurance industry passed double digit rate increases to the consumer. Affordability instead of availability became the problem. In those days, we at the Insurance Department were receiving dozens of telephone calls from people whose complaint was not that they could not find health insurance, but that there was absolutely no

way that they could afford what was being offered them.

Then when President Clinton proposed a nationwide, single-payer health care system as the solution to rising health care costs, I, like most of you, opposed it because there were just too many downsides to it. It was something I doubted the American public was ready to accept.

Then something happened that probably neither you or I expected. In a very short span of time the private health care industry picked up the ball and ran with it. It might be even more accurate to say that the private health care industry forced a solution upon us that we are all now trying to live with.

The private-sector's solution to the problem of rising health care costs was called managed care, and it was basically designed to cut health care costs by stressing health and wellness and lower-cost solutions to health problems. Most managed care groups have guidelines that define acceptable treatment for common conditions, and require providers to follow the guidelines.

While this explanation may sound simple, managed care, of course, is anything but simple. These changes really have come upon us too fast for any of us to absorb. Only three years ago, everyone was debating the Clinton health care reform plan. Now, even the experts are struggling to keep up with all of the changes to our health care system that are continuing to come down the pike at a dizzying speed.

I don't think that anyone in this room really has any idea where all of this is going to finally end up. But looking at managed care purely from a fiscal perspective, it does appear to be generating some cost savings. Medical cost inflation is now holding constant with inflation in other goods and services.

Throughout the late '70s, the 1980s and early 1990s, health care costs typically grew in the double digits or even at twice the rate of inflation. According to Consumer Digest, by 1994, annual health care inflation had dropped to 6.4 percent, the lowest rate in 35 years. And last year, the rate of health care inflation dropped to only 5.5 percent.

Managed care does appear to be replacing traditional indemnity insurance as the norm. Enrollment in managed care plans has increased at a tremendous rate during the past few years, even making inroads into Mississippi. Last year, 70 percent of Americans were covered by managed-care plans.

To me, the arrival of managed care as a solution to health care costs has been very ironic. Those who opposed President Clinton's national single-payer health care plan - including your group and me, and, in particular, those in the insurance industry - did so on the grounds that it would restrict patient choice.

Yet that is exactly what the private sector's solution to the health care cost crisis - advocated by the same industry and group of people who fought Clinton's plan- has done: restricted patients choices in health care in exchange for cost savings.

Of course, it's not a bad thing when restrictions applied to patients' health care options result in the same level of care while cutting its cost. Then everybody benefits, because beneficial health care becomes more affordable for everyone.

But when we have situations where doctors become reluctant to refer patients to specialists or hospitalize them because the cost is either going to come out of their pocket or could have an impact on that doctor's employment with a particular managed care entity, that does concern me as a regulator responsible for representing the interests of health care consumers in Mississippi.

Most of you are aware of the many horror stories that have circulated nationally about cases of denied treatment and tragic results that have occurred in some managed care settings. Much press attention and negative publicity has been focused, rightly so, on the "gag rules" that some Health Maintenance Organizations (HMOs) - the most restrictive form of managed care - have imposed on doctors to prevent them from telling their patients about the best treatment options available that may not be covered by that patient's managed care plan.

In the past several years, there have been about 2,000 attempts at the national and state levels to impose controls on different aspects of managed care. Federal legislation already has addressed controversial issues such as "gag" rules, outpatient mastectomies, access to specialists, and emergency- care coverage. Congress has passed laws ending so-called "drive-by deliveries" by requiring that new mothers be allowed to stay in the hospital for at least 48-hours.

Fortunately, many managed care entities are taking notice of the legislative climate and are voluntarily changing their own rules, getting rid of gag clauses, easing therapy restrictions, and relaxing referral rules to make it easier for patients to visit their own specialists when needed.

I can tell you that from 22 years in the field of insurance regulation, that this approach of "self-regulation" is far preferable to the undesirable alternatives of legislative mandates, class-action lawsuits, and other "legal" remedies. As we all know, both health care providers and their patients lose when the regulators and

lawyers get involved, leaving the consumer nearly always in a worse position.

While managed care entities should be encouraged to ease unnecessary restrictions, we have to remember that as restrictions are eased, someone must pay the price. It's very clear that all of us involved with managed care in this state are going to have to perform a very precise balancing act if the system is going to work well for everyone. Remember that the consumers, your patients, are the ones in the middle of this struggle between the attempt to keep costs down while their medical needs are handled safely and professionally. And it may be inevitable that as these changes occur, some segments are going to have to make sacrifices. There is no going back to the days of traditional fee-for-service medicine.

In many ways, managed care to me is like what is going on in so many other areas of the economy - the inevitable trend towards "bigger" as being "better", exchanging lower cost for lack of personal service. I like to use what I call my lawn mower belt analogy. On the weekends, my sons and I have a yard service. I can go down to Economy Hardware Store in Clinton and buy a lawn mower belt and they will help me install it on my mower for about $12. Or I can go to down to Wal-Mart or Home Depot and buy a belt for $5 and they will say, "Have a nice day."

The moral here, of course, is that there are often trade-offs to consider when you pay less for what you get. If consumers want to continue to benefit from the lower premiums and co-payments they are getting under managed care, they are going to have to accept restrictions on care or pay for supplemental care themselves, since government and business are no longer willing to do so.

As Insurance Commissioner, I see my role as walking that fine line to assure that health care remains affordable - which managed care is helping to accomplish - and guarding against the possibility of substandard care and consumer abuses of all kinds.

Throughout my 22 years in office, I have worked to put many measures in place that protect both patients and the right of physicians to provide the treatment that they see fit in accordance with the best ideals of the doctor-patient relationship. In 1977, a year after I was first elected, the Department was instrumental in helping to establish and develop the nonprofit Medical Assurance Co. of Mississippi, which helped eliminate the critical shortage of medical malpractice insurance available to the state's physicians. In 1985, we sponsored and helped enact legislation establishing the Mississippi Life and Health Insurance Guaranty Act, which protects the public from insolvent health insurance companies. In 1989, we won approval of legislation requiring insurers to either pay or deny accident and health insurance claims within 45 days after receipt of proof of loss and to require payment of interest by the insurer on claims not processed in a timely manner.

Another victory for patients and doctors came in 1991 with the formation of the Mississippi Comprehensive Health Risk Pool Association, which has become the "health insurer of last resort" for thousands of Mississippians in this decade, guaranteeing that nearly every Mississippian will have some access to health insurance.

People typically enroll in the Risk Pool for a relatively short period of time, such as when they are between jobs, entering retirement, or waiting until their health improves before entering the private health insurance marketplace.

Mississippi has one of the best Health Insurance Risk Pools in the country because, unlike most such pools, it is funded by mandatory assessments on companies in advance of claims. Ours is one of the few Health Insurance Risk Pools in the country - and the only one in the Deep South - to which everyone has access.

Although the Risk Pool was organized to address the difficulty of getting coverage in the traditional health insurance market, I think it will have even more of an impact as we make the transition to managed care. Since Mississippi is such a rural state, it is not economically feasible for managed care to exist in all parts of the state, so the traditional indemnity fee-for-service system will continue to be an option for a significant part of our population. Also, managed care plans - particularly HMOs - have been accused of "skimming" young and healthy populations while discouraging older people who are more likely to have chronic health problems. That is going to create problem for the 10 percent of the population who have chronic or complex health problems. These folks, who account for 80 percent of overall health care costs, need access to doctors familiar with unusual conditions, complex medications, and possible experimental approaches that are not covered by most managed car plans.

With the rise of managed care as a solution to the crisis of increasing health care costs, many states, including Mississippi, began passing legislation to address financial solvency concerns pertaining to insurance companies and HMOs.

Managed care has come to rural states such as Mississippi much more slowly than it has to other parts of the country, and it is still a fairly new concept to our area. From a financial solvency standpoint, we as regulators

initially were skeptical of managed care because we didn't want to be like Florida where several HMOs went belly-up during the 1980s. Adequately capitalizing a risk-bearing managed care organization takes a tremendous amount of money, and since we at that time had been through several insurance company insolvencies, the last thing we wanted to do was to enter an area where we had no experience without the necessary legal authority and practical experience.

By the mid-1990s, however, there were several managed care plans that were trying to enter the Mississippi marketplace, so finding ways to make sure that HMOs were solvent became one of the most important issues facing the Department. Our main concern was to not let anyone without proper financial backing just walk in and start an HMO.

In 1995, we won passage of the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act in the state Legislature.

This law requires any HMO or risk-bearing managed care organization formed after July 1, 1996 to have $1 million deposited with the state.

Along with strict financial requirements and oversight, the HMO law also includes some very important protections which guarantee that physicians - not highly-paid managers and administrators - have the ultimate say about their patients' health and well-being.

Mississippi's HMO law requires that a managed care entity submit a copy of their patient grievance procedure and quality assurance plan to the Insurance Department and Health Department for approval before they can be licensed to operate. Also, it requires that HMOs' services "shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice." Importantly, this provision prevents HMOs from imposing "gag" rules on doctors, placing the quality of the patient's care under the treating physician. The law also requires the HMOs to submit written plans which outline in detail the quality assurance measures in place, including the duties and responsibilities of the designated physician responsible for those activities.

Under this law, HMOs are required to put an ongoing system of quality assurance in place, which includes problem identification and study, corrective action, and interpretation and analysis of patterns of care given to patients. Records of these practices are available to the State Health Officer, who is required to do an examination of the HMO's quality assurance program once every three years. If the HMO does not follow these standards, its license and certificate of authority can be revoked. Both the State Health Officer and the Commissioner of Insurance can call hearings to elicit evidence to determine whether an HMO is operating under the provisions of these statutes, and the Commissioner of Insurance has authority to issue cease and desist orders preventing an HMO from engaging in illegal practices.

For the last couple of years, I have been very interested in watching how other states keep tabs on the quality of care provided by HMOs. Last year, we saw the rise of Proposition 216 in California - which many observers said represented a "backlash" against managed care - only to see it go down in defeat at the polls in the November '96 Presidential election. To me, that defeat sent a signal that the general public is not willing to abandon managed care altogether.

Whether managed care is successful in Mississippi will ultimately depend on whether the patient is willing to give up choices for cost savings. All the indicators that I have seen indicate that consumers here like the cost savings.

Currently, there are fourteen (14) HMOs licensed in Mississippi with about 55,000 enrollees. Mississippi HMOs have an estimated 98 percent retention rate, which would seem to indicate that even the limited penetration of HMOs in Mississippi is somewhat successful so far.

The federal government's participation in managed care in Mississippi also is being watched very closely. To control its costs, the federal government is very interested in experimenting with managed care for seniors covered under Medicare and poor and disabled folks covered under Medicaid.

At the beginning of this year, nearly 15 percent of Medicare beneficiaries nationwide had enrolled in HMOs, with 1 million additional enrollees expected by the end of the year. Because Mississippi has a very high percentage of Medicaid enrollment, many HMOs have been interested in coming here to capture the guaranteed stream of patients. However, some of those entities will probably go out of existence because there was no state funding made available for Medicaid participation in HMOs during this past year's legislative session.

On the other hand, the involvement of the Medicare program in managed care in Mississippi could strengthen and expand the number of HMOs licensed here. The federal government wants to encourage as many of its Medicare enrollees as possible to participate in HMOs to reduce costs. Recipients of traditional Medicare benefits who enroll in a Medicare HMO can receive enhanced benefits such as lower physician copay amounts and flat pharmacy costs. HMOs want more Medicare patients

because they represent a guaranteed stream of patients. Many employers want to have access to Medicare HMOs in order to benefit their retirees.

But in order for an HMO to qualify to accept Medicare patients, at least half must come from the private sector. There also is a requirement that all public-sector patients be in a 30 minute/30 mile service area, which may make people in many areas of Mississippi unable to qualify for Medicare HMO coverage.

However, we have had some indications that Medicare HMOs may be licensed on a county-by-county basis beginning in 1998, probably starting with Batesville, the Gulf Coast, or the Hattiesburg/ Jackson area.

Up to now, the most common form of managed care plan in Mississippi has been the Preferred Provider Organization (PPO), which is the second most restrictive form of managed care. PPOs have proven to be a more successful approach for managed care in Mississippi because they offer much more flexibility for patients than an HMO. A patient in a PPO arrangement can go to a certain group of doctors, who have agreed to take reduced fees for performing specific services. Of the 80 percent of Mississippi's health care insureds that are now in some form of managed care, most are enrolled in a PPO, such as your organization's own Mississippi Physicians' Care Network.

Although PPOs are part of the HMO law, they are not subject to the law's financial requirements or quality assurance provisions because they are non- risk-bearing entities. However, because the vast majority of PPOs are in fact groups of doctors which contract with HMOs, the responsibility of financial solvency is in effect transferred to the HMO. Determining whether managed care entities are taking on risk is the most important thing we look at in trying to figure out how to regulate them.

Another example is the development of the Point of Service (POS) contract or plan. This is a plan that has an opt-out provision which allows an enrollee to see a physician outside of the managed care network and still receive some benefits. If he does go outside, he reverts back to traditional indemnity coverage with additional out-of-pocket costs. A primary care physician coordinates the care in a POS plan and makes referrals to specialists in the network.

The Department also is tracking regulatory developments in other states impacting Provider Service Organizations (PSOs) that many of you may have heard about. Different types of PSOs include Physician-Hospital Organizations (PHOs), Provider Services Networks (PSNs), Individual Practice Associations (IPAs), and other types of organizations that may or may not accept direct financial risk associated with providing medical services. All of these groups are just another example of the tremendous changes that are constantly going on within the managed care marketplace.

The growth of these risk-bearing PSOs has prompted many state insurance departments as well as the National Association of Insurance Commissioners (NAIC) to look for ways to protect consumers from insolvency and inadequate care without reducing competition, increasing costs, or stifling innovation.

The insurance and managed care industry's argument is that PSOs might benefit from an unfair competitive advantage because of an "unlevel playing field" created by inconsistencies in regulation between PSOs and licensed HMOs and health insurers.

Employers and the PSOs argue that regulation of their operations could create barriers to entry that would reduce competition in the managed care marketplace and increase costs.

State insurance departments, working through the NAIC Risk- Bearing Entities Working Group, are trying to streamline the process by making sure that the level of regulation is consistent with the nature and level of risk assumed by each entity.

The issue of PSOs underscores the fact that it is going to take each participant to help create an environment that balances the health care provider's need to compete in the marketplace with the insurance regulator's obligation to protect consumers.

To accomplish this, we all have a tremendous amount to learn. During the past two years, for example, the Mississippi Insurance Department has been primarily concerned with gearing up to provide adequate regulation of the financial solvency of HMOs and managed care groups. Where appropriate, we are trying to get managed care organizations accustomed to the strict financial standards expected of insurance companies or other risk-bearing entities, since solvency is the Department's main concern in this area.

With the decline of traditional health insurance and the rise of managed care, the Department is directing more attention and resources to the oversight of the quality of the health care service that is being provided to patients. When we were just regulating health insurance, we were just regulating a reimbursement mechanism. Now, with managed care, we are regulating a service also. This is an entirely new area for us.

One of the areas of common agreement among all of the major stakeholders in managed care is in the area of consumer education. The Insurance Department is prepared to take a leading role in this effort, but it needs

your support and involvement if we are to be successful.

Finally, I think that what all this points to most of all is the need for the medical community and the insurance industry to talk and work together on the front end of the continuing evolution of health care reform. This is necessary to create an environment that balances the need of the managed care entity to compete in the marketplace by keeping coverage affordable with the provider's obligation to render care that is beneficial to the consumer. By the time each side's lobbyists square off at the state Capitol, it is too late.

As I see it, each side in the debate over the continued evolution of managed care makes arguments that are equally important in furthering the public interest. The managed care entities are working to keep costs down to keep health care affordable and accessible. The medical profession wants to make sure that the quality of care is not sacrificed for profit.

In a competitive marketplace, we need health care that is both affordable and of uncompromising quality. This kind of health care is going to be of the most benefits to employees, partners, owners, investors, and ultimately, of course, the consumer.

As managed care continues to evolve in Mississippi, I call on your group to work with our agency to create an open forum with managed care entities and consumers where an ongoing dialogue can occur. This dialogue would center on all of the issues that need to be considered as managed care continues to unfold in this state. We as regulators can't make policy in a vacuum, and we can't fully address the concerns of consumers in this "brave new world" of managed care alone. You are the front line troops in this effort, and HMOs and PPOs can not operate without the cooperation and assistance of your members. We need your input in addressing these issues. Thank you.

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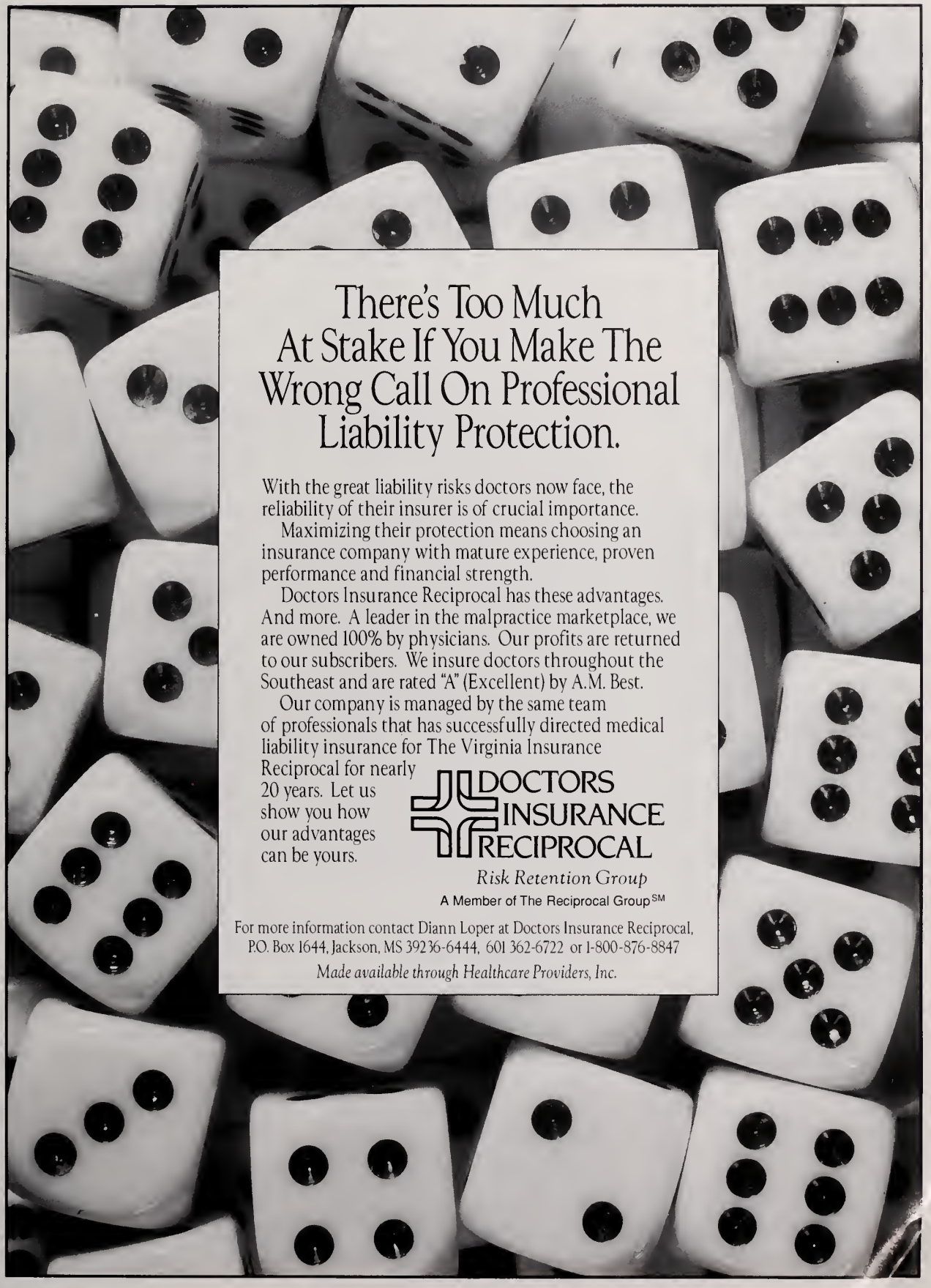
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Address of the President
MSMA House of Delegates - May 15, 1997

Mister Speaker, fellow officers, members of the Board of Trustees, members of the House Of Delegates, Dr. Nelson and guests.

I'll have to tell you that I'm in a little bit of a pickle this morning. You see I thought my remarks were to follow those of AMA Board of Trustee member Dr. Nelson and had planned on using a tactic that the lawyer and wit Chauncey Depew used when he was to speak at a banquet along with Mark Twain. Twain spoke first and met with great applause. Depew rose and began "before dinner Mark Twain and I swapped speeches. He just delivered mine and I am grateful for the response it received. Unfortunately I have lost his and can't remember a word of what he had to say." With that he sat down. After seeing the program schedule this morning, fortunately I had time to prepare a few remarks.

Before I begin, indulge me to take your picture. Such a room full of good looking smiling faces! Now this photo is for me. Karen has assured me space for at least one of my photos in the Journal, so if I see any nodding heads during my presentation — a photo opportunity.

I had a most difficult time in composing my thoughts on what I wanted to say to you this morning. I thought about our common past and how we arrived at where we are today. Physicians practicing good medicine, having a measure of financial security and enjoying a sense of gratitude from our patients.

The difficulty is making a transition to the future. What can we do to ensure a bright future individually — collectively — and for those who follow? The problem with the future as someone once said, "it ain't what it use[d] to be." We tend to manage for yesterday's conditions, because yesterday is where we gained our experience and our success. It is nearly impossible for most of us to view old problems from a new perspective. For instance how many of us have thought of looking at the proverbial half glass of water as simply too large a glass. This lack of ability to easily adapt is causing:

Patients to feel like they are losing control over their care.

Physicians to feel like they are losing control of their practice.

And everyone to feel like we are losing control over our ability to pay for health care.

Physicians are overwhelmed and confused because of a sense of loss of control of health care. There is a traumatic change, not only in the method by which we are reimbursed for our services but in the level of compensation...not only causing a direct attack on the exercise of our professional judgment, but a fear of loss of patients due to market forces beyond our expertise to control.

I cannot tell you how to immediately solve this dilemma. Other leaders in MSMA, in our speciality societies and in our AMA cannot solve this dilemma. However, coming together with the input of all and the cohesiveness of all, we will.

Let's take a few minutes to look at what physicians thought was important 150 years ago. What did every physician strive to adhere to in order to retain the privilege of being a physician? Why did physicians gain such high respect among the public? — going from snake oil doctors to the most respected professional group and most highly respected individuals in their community. What guiding principals did physicians establish then that maybe we do not follow now? Here they are as extracted from Dr. J. Bell's remarks in 1846 as Chair of the Committee on Ethics:

1. Doctors must answer to a patient's call regardless.

2. Doctors must treat all humanity.

3. Doctors must keep confident all information about the patient.

4. Doctors not only have a relationship with their patients and to each other, but also to the public (this

latter part was uniquely American). This relationship with the public includes:

a. Education of the public.

b. Treatment in times of epidemic.

(We must remember that physicians at that time had no way of protecting themselves from disease.)

5. Doctors fees must be based on a sliding scale according to the patient's ability to pay.

There was no expectation of a certain income — just treat everybody regardless of their ability to pay. They were not concerned with how many indigent patients were in their waiting rooms or on their chart of accounts. Physicians read this code in the medical schools, town halls and churches. In fact, it was the most read document of the times. If a physician broke the code he also broke his tie to the profession and not being accepted in organized medicine then was tantamount to not being licensed.

Before health insurance, we depended on the patient for reimbursement. The amount charged was related to the patient's ability to pay. Then health insurance developed mainly in response to large employers needing to add benefits during the wage freezes required by World War II. This required an adjustment by physicians. Later Medicare and Medicaid were enacted in response to calls for better access to health care by the elderly and needy and another adjustment by physicians in the business side of medicine was required. As with other governmental programs there developed extensive waste, inefficiencies and yes, some abuse and fraud. This along with increasing levels of technology has spawned an increase in the cost of health care to where it represents 14% of the gross national product. There was a time when health care came out of a doctor's black bag. Increase in technology shifted health care to the hospital.

Now, once again, employers are seeking change. Providing for the health care of their workers has created more expense than they are willing to accept. They have cut this expense by decreasing the amount of health care. Rationing such care through a scheme devised by third party payors that gives those parties the same or more profits while decreasing the costs for the employers. First it was gate keepers, and now it's capitation which effectively shifts 100% of the financial risks to us while third party payors keep 20% off the top of the premium dollars.

Employers are now beginning to realize that quality not just cost must be considered. They do not want their employees missing work because of illness and therefore being inefficient. The public also is realizing they must insist on quality. They do not want drive by deliveries, lack of choice of physicians, or restriction of treatment options.

At the same time there is all this rhetoric between medical specialty groups over who will profit over the other. This has resulted in 43% of the public feeling most physicians are opposed to health care reform — and they are probably right. More alarming, there are polls that show the public has the perception, although false, that wealthy physicians are in cahoots with insurance companies to keep medical care unaffordable for most people. Sixty percent feel they are unable to afford quality medical care for a serious illness. Two polls reveal that a majority of Americans are worried about the quality of the health care system. Eighty percent want to be better informed about evaluating the quality of the health care they are receiving and 72% want more data to help them make decisions about their own health care.

These are big numbers. They indicate a large public need. Somebody is going to fill this void. Either we do and regain a measure of control over our livelihood and the public health — or we forfeit control into the hands of those who authorize reimbursement. *Leadership unused slips imperceptibly into the hands of others.* Medicine is a way of life. The more control we exert over that way of life the more comfortable we will be. The more we feel we are really helping patients the more satisfying our professional life will be.

Why have we lost the momentum? Partly because we did not see the control of the cost of medical care as a timely issue. We were more focused on ensuring access to quality care. We have an opportunity to reestablish ourselves as the credible leaders in health care delivery by uniting to assure overall good patient care at an affordable price. The issue will be **quality care** not rationed care — **patient choice** not mandated panels — **efficient care** not potentially unaffordable care. In other words, the issue must be **value** not cost.

Very few physicians are trained to cope with practice management, business administration and corporate finance. These were not part of my medical education. We are overwhelmed individually and even in large groups. There are so many fronts — legislative, bureaucratic, corporate. The later includes both managed care entities, employer groups and aggressive hospitals.

Much of the increase in the cost of providing quality care has come about as a result of the volume factor. We physicians in the U.S. provide more care than is given in any other country. Occasionally providing care that is of marginal value or even futile. Not out of avarice or malpractice but because professional liability, regulators and the public demand it.

Tort Reform
Development of practice parameters.
Outcome studies.

These are needed so we can shift not only our thought processes but the publics' as well to what constitutes quality health care. In doing so we will be better able to differentiate from doing everything scientifically possible, to doing what can improve a person's well-being and thus not adding undesirable or even unbearable burdens to the patient and society. These I know are being accomplished in ophthalmology and in other specialities through collaborative multi-center trials of various treatment modalities.

Another contributor to the large volume of medical care being given is the aging of the population. Thirty percent of all Medicare costs are spent in the final year of life. This makes practice parameters and outcome studies even more important so that there is more scientific rationale for when to do what.

A third contributor to the volume issue is the illness and injury that result from poor public health practices and societal crisis. Four hundred thousand smokers die yearly. Caring for those that do not die costs 52 billion dollars yearly. Violent assaults leave over 45,000 men, women and children quadriplegic yearly requiring $600,000 per victim for a lifetime of care. Yearly there are 375,000 drug exposed babies starting life at a cost of 24 billion dollars for their care over 5 years. Just these three examples total more than 300 billion in health care costs over 5 years. A reduction by a third would more than cover Clinton's proposed cuts in Medicare payments.

Society has decided that quality health care is a right. We must continue to help keep the focus on the cost to the individual and to society of this risky behavior. Those that continue in this behavior must assume more of the costs. It is not our responsibility to decide how they should share in this cost. We should make it an issue so that the populace pushes for needed reforms. A major emphasis on education is paramount. Long term commitment will be needed for this to filter from early school age into family values. We already have the AMA's campaign on teenage smoking and our school health education emphasis.

We must preserve pluralism in the delivery system of health care. No one method is perfect. MSAs, capitation, PHOs, HMOs, provider services organization and continued fee for service.

What are we to do today and tomorrow — individually and collectively? You are already doing much to help our colleagues by devoting your time to hear and understand the issues — voicing your opinions — and taking a stand together on a course of action. When we go back to our communities we must help others focus on solutions not problems — the future not the past — and on the rewards of medicine not the negatives.

We have formed our own managed care company — MPCN. Jimmy Waites will tell you how it continues to grow. MPCN is a rebirth of our efforts several years ago — David Steckler will tell you how that effort through writing workers compensation insurance is succeeding with MPIC which could play a part in our managed care efforts in the future.

Health care is going to be reformed. The reform will take place legislatively in Washington and in the state capitals. It will also take place through market forces. We have already seen state legislatures willing to look to physicians for guidance on patient protection clauses. Our Mississippi legislature has also demonstrated a "take it slow" attitude on HMO's as illustrated by its rejection this year of an expanded Medicaid HMO project while increasing Health MACS. In Washington the AMA's health care proposals are being given serious consideration and have been lauded by congressmen and news media alike as being the only proposal that puts the patient first at an affordable price. Meaningful antitrust regulatory relief has also been enacted moving physicians to a more equal footing with insurance companies.

As I said earlier, the market forces will, over time, stress quality care at an affordable price. We have the potential to effect persuasive influence over this process if we keep our patient's best interest in the forefront and continue to be the patient's advocate. This does not translate into cheap care. The public knows and understands that quality care comes at a cost. However, by eliminating the inefficiencies, waste and excesses in the system, we can assure access to quality care at an affordable price. Locally we do this in our own MPCN. Globally we do this through practice parameters and outcome studies. Not the old peer review that has been done at hospitals and not through profiting as done by insurers and managed care companies. New attempts at assuring quality of medical care will probably be viewed with skepticism because of our past experience with peer review; however, I think we should embrace these new efforts for two reasons. They are being done through clinical collaborative efforts so that the data can be seen both to be scientifically justifiable and to improve the quality of care we deliver. This will give us renewed autonomy over the practice of medicine. This will allow us to cut the cost of medical care in the U.S. by reducing proven inappropriate use of health services and preventing adverse effects. At the same time qual-

ity of care given will improve. We will be better able to inform our patients and their families of options and expectations. All this will *empower* physicians to take the leadership in assuring quality and value.

We will once again be like the seamen first class. Late one night it seems the captain of the ship saw what looked like the lights of another ship in the distance. He had his signalman blink a message — "change your course 10 degrees south." The reply came back — "change your course 10 degrees north." The captain answered back "I'm a captain, change your course 10 degrees south." To which the reply was, "I'm a seaman first class, change your course 10 degrees north." This infuriated the captain. "I'm in a battleship and I say change your course 10 degrees south." The seaman first class blinked back "and I say change your course north, I'm in a lighthouse."

There are other very important areas where health care can be improved and costs decreased. The Harvard Medical Practice study revealed that adverse events occur in 4 % of hospitalizations with 14% of these being fatal. That's big numbers. To put this in perspective, picture this — three jumbo jets crashing every two days year round killing everyone on board. That's the estimate of the number of people who die each year in the U.S. of preventable causes. Certainly we cannot prevent all of these adverse events; however, through meticulous collaborative multi-centered efforts the causes can be identified. Technologies can then be developed to prevent these errors — thereby significantly decreasing the costs and at the same time improving quality.

One area that concerns me that could be contributing to these adverse events is the changing environments in patient staffing levels, such as the use of unlicensed assistive personnel, reduction in registered nurses from 95% to 75% of nursing staff, increased use of leased or temporary nursing staff, and patient confusion over use of allied health personnel for increased levels of care traditionally given by physicians. The AMA has looked at this issue and made the following recommendations. I commit them to you for consideration so that through MSMA we can encourage adoption by the medical and nursing staff in medical institutions.

1. Encourage medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;

2. Encourage medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;

3. Encourage medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;

4. Encourage medical and nursing staffs to develop, promote and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs of each facility; and

5. Encourage medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.

There are attacks on our profession seeking to whittle away at our influence over patient care. All those whose livelihood depend on health care dollars are seeing a decrease in cash flow. The natural movement is to gain influence over physicians because we are both the point of contact between the patient and medical care and between the patient and the reimbursement system. Hospitals are:

-hiring physicians to run clinics in competition with local physicians who may not support them in the manner they want.

-pursuing hospital based physicians to sign exclusive contracts and after success with these groups pressuring other specialties to do the same.

-forming PHOs which upon close inspection often insert hospitals into physicians' practices but not visa versa.

We must band together. Each of us are stronger when we are joined together. There has to be one umbrella organization — a federation of all. The AMA is moving in this direction and I ask your endorsement and support of this effort, not only through this organization, but also through your influence in your specialty associations.

On a more uplifting note, I want to particularly acknowledge the MSMA and AMA Alliance. A life in medicine is truly a family commitment. The Alliance's shared vision plays an important integral part of our professional life, particularly our role as patient advocate. MSMA alliance members have been recognized nationally for their excellence. They have won the AMA's Health Awareness Project Award four times. The awards recognized such projects as Breast Cancer Awareness, Health Choice, Tobacco Awareness, Woman's Life Conference, AMA ERF, abuse shelter projects, the Blake Clinic Project and legislative efforts. I have proposed that through one of

the AMA's legislative programs, selected alliance members be trained in advocacy skills and as mini-lobbyist. I feel this will greatly enhance their already invaluable efforts in the legislative arena. Join me in expressing our gratitude for their successful efforts.

Earlier I talked about the beginning of organized medicine 150 years ago and the elevation in standardization that occurred not only in medical education but also in how physicians should conduct themselves. It was what physicians thought was ethically and morally important, and was held to be important enough to require adherence to by all that earned the respect to be called a physician. We have lost some of this because of organized medicine's inability to respond to the challenges put to physicians beginning in the early 1900's by society and by the fragmentation that arose from the specialists who split off forming their own groups. The AMA is seeking to be more responsive to all specialty groups. We must help push this attempt at inclusiveness by the AMA. I ask you to formally take a position of support of the AMA's federation reorganization.

It was no easier for physicians 150 years ago to gain the high ground than it will be for us today. They did and we must — using the same principals. Then it was consistency of medical education, welfare of the public health, reimbursement for physician services and access to appropriate medical care. Today I ask you to:

1. Assist in assimilating a strong federation — bringing all specialty organizations a voice and a collaborative effort under one umbrella by endorsing and actively supporting the AMA's efforts in this regard;

2. Encouraging our speciality associations to develop practice parameters and outcome studies through collaborative multi center efforts so as to empower us with the scientific knowledge to regain the leadership in assuring quality and value in the deliver of health care;

3. Expand our efforts in public health by asking our Board of Trustees to appoint a committee to develop and implement a plan which would incorporate MSMA, the Mississippi State Department of Health, employer groups and others, such as educators so as to make meaningful inroads into the public welfare by causing them to change their behavior that puts their health at risk;

4. Continue our efforts in meaningful tort reform not only legislatively but also through physician education as MACM is doing.

There had to be nay sayers in the mid 1800's putting their special considerations above the general good of the community and of patients and physicians. Just, as by being the patients' advocate then, physicians and the public won out — so will we.

In closing I must say that all of you should have the opportunity to do this — being President of MSMA. This past year has been one of the most fun, most rewarding and learning years combined. Traveling to other component societies, being treated so hospitably — receiving, on your behalf, the accolades I have heard for the respect physicians have in our state. I sincerely thank all of you for giving me the opportunity to be the spokesperson for your hard work and successful efforts. On Sunday it will be with firm confidence that I look to Vann Craig's leadership this next year.

Thank you!

Fred L. McMillan, M.D.

Attention: Physicians



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MSMA 129th Annual Session



H. Vann Craig, MD, (center) of Natchez was installed as 1997-98 MSMA President during the closing session of the MSMA House of Delegates on Sunday, May 18. Michael H. Carter, Jr., MD, of Greenwood (left) was named president-elect. Fred L. McMillan, MD, of Jackson (right) is immediate past president of the Association.

Dr. Craig Installed as Association President; Dr. Carter Named President-Elect

MSMA conducted its 129th Annual Session, May 15-18, 1997 at the Grand Resort Hotel, Biloxi. Dr. Vann Craig of Natchez was inaugurated as MSMA's 1997-98 President and Dr. Michael H. Carter, Jr. of Greenwood was elected to the office of President-elect. MSMA's Community Service Award was presented to Dr. Tim J. Alford of Kosciusko. The House of Delegates expressed its wishes on a variety of issues facing the medical profession and among many actions voted affirmatively 94-30 by written ballot to continue unified county, MSMA and AMA membership and directed that MSMA membership support for capitalizing a health insurance company be determined by a survey. Discussion was lively in both the House and reference committees. Non-members were specifically invited to address the unified membership question when it was considered by a reference committee. Attendees also heard speakers on several current medical practice topics to include physician supply and medical education funding issues, plans for a Mississippi trauma system, consumer protection and managed care, Medicaid's managed care initiatives, and current trends in professional liability suits.



1996-97 MSMA President Dr. Fred L. McMillan addresses the 129th Annual Session House of Delegates.



Dr. H. Vann Craig (right) is installed as 1997-98 MSMA President during the Sunday morning meeting of the House of Delegates. MSMA Executive Director Charles Mathews (center) holds the bible while 1996-97 Chairman of the Board Dr. Michael H. Carter administers the oath of office.

Newly Elected Officers, Board & Council Members

Serving as Serving as MSMA Board members and officers during the 1997-98 association year will be: Julian C. Henderson, MD, Jackson, Chairman; Hal Moore, MD, Pascagoula, Vice Chairman; Dewitt G. Crawford, MD, Louisville, Secretary; Ben M. Carmichael, MD, Hattiesburg; William A. Spencer, MD, Oxford; T. Steve Parvin, MD, Starkville; John J. Cook, MD, Jackson; Chester W. Masterson, MD, Vicksburg; Hugh A. Gamble, II, MD, Greenville; H. Vann Craig, MD, Natchez, President; Michael H. Carter, Jr., MD, Greenwood, President-elect; Fred L. McMillan, MD, Jackson, Immediate Past President; and Candace E. Keller, MD, Hattiesburg, Secretary-Treasurer. Mrs. George (Jane) Ladner, President of the MSMA Alliance will serve as the Alliance representative to the Board.

President-Elect
Michael H. Carter, MD, Greenwood

Delegate to the AMA
Don Q. Mitchell, MD, Jackson

Alternate Delegate to the AMA
Candace E. Keller, MD, Hattiesburg

Delegate to the AMA
Fred L. McMillan, MD, Jackson

Alternate Delegate to the AMA
James Fuller, MD, Jackson

Delegate to the AMA
James C. Waites, MD, Laurel

Alternate Delegate to the AMA
Mary Gayle Armstrong, MD, Madison

Associate Editor, Journal MSMA
Dwalia S. South, MD, Ripley

Board of Trustees, District 1
Hugh A. Gamble, II, MD, Greenville

Board of Trustees, District 3
T. Steve Parvin, MD, Starkville

Council on Budget and Finance
George R. Bush, MD, Laurel

Council on Budget and Finance
John J. Cook, MD, Jackson

Council on Budget and Finance
Clark G. Warden, MD, Pascagoula

Council on Constitution and By-Laws
Elmo P. Gabbert, MD, Meadville

Judicial Council, District 6
A. Jerald Jackson, MD, Hattiesburg

Judicial Council, District 7
David G. Hall, MD, Natchez

Judicial Council, District 8
Donald K. Gaddy, MD, Gulfport

Council on Legislation, District 4
John E. Studdard, MD, Jackson

Council on Legislation, District 5
Charles L. Wilkinson, MD, Meridian

Council on Medical Education, District 6
H. Creed Fox, MD, Hattiesburg

Council on Medical Education, District 7
R. Calvin Masterson, DO, Vicksburg

Council on Medical Education, District 8
David L. Reeves, MD, Long Beach

Council on Medical Service, District 6
John M. Wallace, MD, Laurel

Council on Medical Service, District 7
Joe M. Ross, Jr., MD, Vicksburg

Council on Medical Service, District 8
Charles J. Winters, MD, Ocean Springs

Council on Public Information, District 7
R. Lee Giffin, MD, Vicksburg

Council on Public Information, District 8
Richard S. Whitlock, MD, Pascagoula

Chairman, Medical Planning Group
John E. Moffitt, MD, Jackson

Nominees for the Mississippi Board of Medical Licensure elected by the House of Delegates were: Drs. Leonard Brandon, Starkville; W. Joseph Burnett, Oxford; Dewitt G. Crawford, Louisville; Walter C. Gough, Drew; Stanley A. Wade, Jr., Meridian; Hardy B. Woodbridge, Jr., Jackson; Frank W. Bowen, Carthage; John Paul Lee, Forest and Joe M. Ross, Jr., Vicksburg.

Actions of the House of Delegates 129th Annual Session

MSMA's House of Delegates considered reports from the Board of Trustees and Councils as well as numerous resolutions.

Delegates elected by MSMA's component societies considered the reports and resolutions. Among actions taken by the Delegates were the following:

- Directed that a membership survey be conducted to determine support for capitalizing a health insurance company.

- Voted 94-30 to continue unified county, MSMA and AMA membership.

- Expressed appreciation to the American Association of Medical Society Executives (AAMSE) and MSMA's members of the society for their service to the medical profession during this, AAMSE's 50th Anniversary.

- Urged the AMA's effort, through the Study of the Federation and the Federation Coordinating Team, to define the common thread among all physicians and to restructure and revitalize organized medicine to reflect the shard values and characteristics of the medical profession.

- Adopted recommendations of the MSMA president (Dr. McMillan) that: (1) all members work toward uniting all specialty societies by addressing and supporting the AMA's efforts to strengthen the federation; (2) that speciality societies by encouraged to develop practice parameters; (3) that efforts be expanded to improved the public health; and (4) that meaningful tort reform continue to be sought through legislation and education of the membership.

- Urged each state specialty society to appoint a liaison person to work with the MSMA Council on Legislation and staff.

- Commended and urged the Council on Legislation to continue its initiatives to increase the involvement of the MSMA membership and Alliance in legislative efforts.

- Commended Drs. J. Elmer Nix, Sidney Graves and J. Edward Hill for their outstanding service on behalf of MSMA in the AMA House of Delegates.

- Supported legislation to extend the state's immunity for the voluntary provision of indigent medical care to church, civic and other defined organization.

- Expressed opposition to attempts to criminalize coding errors and punish physicians for their decisions regarding the necessity for medical services and directed that the state's Congressional Delegation be made aware of this opposition and that the AMA also be urged to express its opposition.

- Urged equal Medicare/Medicaid payment for the same services whether provided in a physician's office or by a rural health clinic.

- Urged funding by the Mississippi Legislature for an education program for grades 1-6 following "Guidelines for School and Community Health Program to Promote Lifelong Physical Activity Among Young People" issued by the Center for Disease Control.

- Supported a Medicine/Public Health Initiative grant application and urged participation in the initiative by the MSMA membership.

- Directed the Council on Medical Service to study recommendations of the American Academy of Neurology relating to recurrent brain injuries and as appropriate disseminate such recommendation to the MSMA membership and school officials.

- Expressed opposition to expansion of commercial managed care organization that contract with Medicaid on a capitated basis.

- Urged implementation of the Medicaid Medically Needy Program.

- Supported legislation to require vehicles to have their headlights on when their windshield wipers are on.

- Referred to the Board of Trustees for action a resolution supporting the states awarding peer review contracts to the best company submitting a proposal and expressing a desire to see the Foundation for Medical Care fill that role.

- Referred to the Board of Trustees for action a resolution urging legislation to fund prevention, early detection and treatment of breast and cervical cancer.❑



1997-98 MSMA President H. Vann Craig and his wife, Elizabeth.



Dr. and Mrs. (Loni Eustace-McMillan) Fred L. McMillan hosted the President's Dinner for the Board. Dr. McMillan entertained his guests by giving them tokens to remember his presidency by. He explained what inspired him to buy each gadget for each guest. Knowing Charles Mathew's protective attitude over the boardroom table inspired him to give those that like to doodle during board meetings toy notepads that erase like magic.



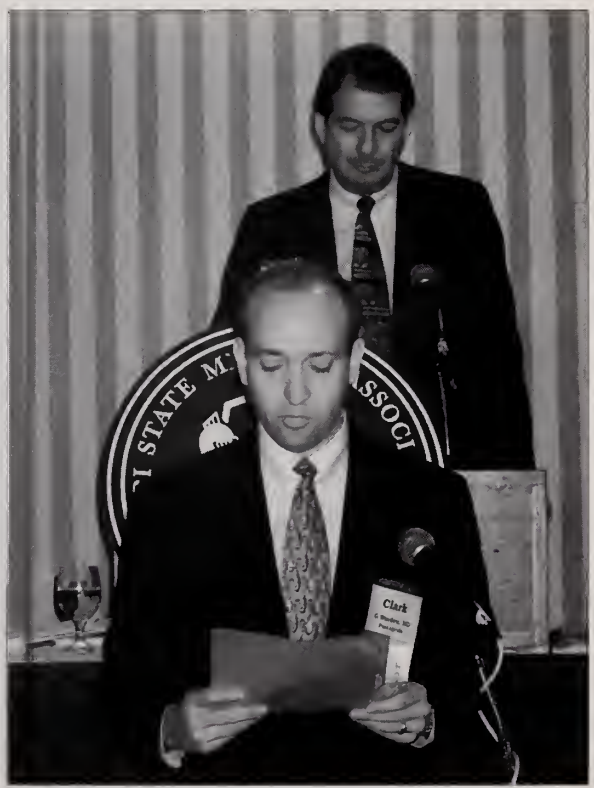
Dr. Candace Keller laughs as Dr. McMillan jokes, "and there were a few of you that just didn't inspire me at all." Dr. Don Q. Mitchell holds up his empty loot bag. He was not alone in this category.



Speaker of the House Dr. George E. McGee of Hattiesburg and Vice Speaker of the House Dr. Daniel P. Edney of Vicksburg helped make the meetings of the House of Delegates productive, interesting, efficient and at times amusing. Upon Speaker McGee's recommendation, the MSMA bylaws were amended to permit use of Davis' Rules of Order as the official parliamentary guide for the conduct of business by the House of Delegates. The parliamentary guide was developed by Dr. James Davis, a former AMA President and Speaker of the AMA House of Delegates. The ***Davis Rules of Order*** *are now being utilized by the AMA and many other medical organizations.*



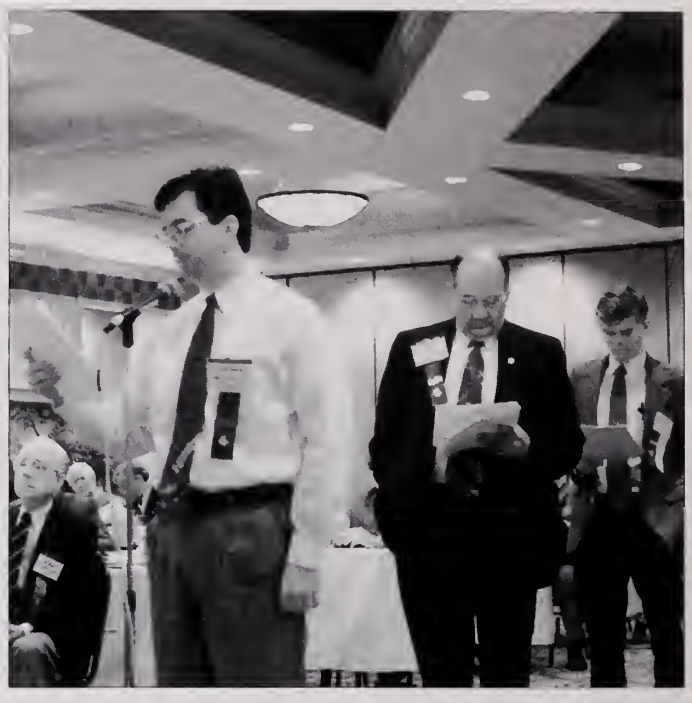
Dr. Nancy O. Tatum of Jackson, Chair of Reference Committee A, presents the Committee's report.



Dr. Clark G. Warden of Pascagoula, Chair of Reference Committee B, presents the Committee's report.



John C. Nelson, MD, Member of the Board of Trustees of the American Medical Association, addressed the Thursday morning session of the House of Delegates.



Reports and resolutions were introduced at the initial meeting of the House for consideration by Reference Committees. Above: Drs. Calvin Masterson, Alfio Rausa and Alexander Blevens.



Attendance was up for the 129th Annual Session.



Steve Demetropoulos, MD, of Pascagoula, introduced a resolution on behalf of the Young Physicians Section which calls for support of legislation to extend the state's immunity for the voluntary provision of indigent medical care to church, civic and other defined organizations.



Leonard Brandon, MD, of Starkville, who was nominated for the Board of Medical Licensure, takes notes on a reference committee report in the House of Delegates.



1996-97 Chairman of the Board Michael H. Carter, Jr., MD carefully checks his ballot.



Michael H. Carter, Jr., MD, of Greenville accepts the office of 1997-98 President-Elect.



MSMA President Dr. Fred L. McMillan (right) presents the 1997 Community Service Award to Timothy J. Alford of Kosciusko (left). The MSMA Community Service Award recognizes an individual physician for outstanding contributions to the betterment of life in his or her community. The award consists of an engraved plaque and a $500 contribution to a charity designated by the recipient.



R. Lee Giffin, MD, of Vicksburg, presents the media award for excellence in the Newspaper Category to Ms. Mandy Jones for her informative article on lung cancer published while she was an intern at The Clarion-Ledger. In the Broadcast Category, Ms. Melanie Christopher, (not pictured) news anchor/reporter for WJTV-12 in Jackson, won for her three part series on Organ Donation. Each received a plaque and a check for $500.



Helen Turner, MD, left, Associate Dean for Academic Affairs at the University Medical Center, is accompanied by (left to right) MSMA President Dr. Fred L. McMillan, Mrs. William H., III (Stancy) Gullung chairman of the Alliance's AMA-ERF Committee, and MSMA Alliance President Mrs. George R. (Nancy) Bush as she receives the annual AMA-ERF award.



Jim McIlwain, MD of Jackson, (left) principal clinical coordinator for the Mississippi Foundation for Medical Care, presented the annual MFMC Derrick award to Glenn Peters, MD of Louisville. The award is given to the physician who provides outstanding physician support of the quality improvement program.



Scott Edwin Harrison, MD, left, was the recipient of the Medical Assurance Company of Mississippi House of Delegates 16th Annual Robert S. Caldwell Memorial Award. The award was presented by Paul H. Moore, MD, MACM Vice-president of the Board (right). The Caldwell Memorial Award is presented by MACM each year in the interest of furthering medical-legal education in Mississippi.



Robert M. Jones, JD, with Medical Assurance Company of Mississippi opened the first plenary session with his presentation of "Case Dissection: the Anatomy of a Claim."



J. Edward Hill, MD, member of the Board of Trustees of the American Medical Association, discussed "Health Care Issues and the New 105th Congress."



Marvin Dunn, MD, secretary of the AMA Council on Medical Education, presented "Health Workforce and Medical Funding and Education Issues."



John Moffitt, MD of Jackson served as co-chairman of the program and is shown introducing the speakers at the Friday Plenary Session.



Ed Thompson, MD, State Health Officer for the Mississippi Department of Health, discussed current and future plans for a regional trauma system.



Keith Thomae, MD, assistant professor of surgery at the University of Mississippi Medical Center, was the James Grant Thompson Memorial Lecturer.



As part of the Trauma Care Panel, Hugh A. Gamble, II, MD, with the Gamble Brothers & ArcherClinic in Greenville discussed "Trauma System Operation in Rural Mississippi."



Bobby J. Heath, MD of Jackson served as co-chairman of the program and is shown introducing the speakers at the Saturday Plenary Session.



The Honorable George Dale, Insurance Commissioner for the State of Mississippi, presented "Consumer Protection and Managed Care."



Helen Wetherbee, JD, MPH, Director of the Mississippi Medicaid Program, discussed Medicaid's Managed Care Program.



Mal G. Morgan, MD, of Natchez and Stephen C. Brandon, MD, of Starkville are shown visiting one of the many exhibitors during a break in the plenary session. This exhibitor is Sandra Tabor with Mississippi Methodist Rehabilitation Center.



Patricia Clark, director of media/speech training services for the American Medical Association, performs a mock interview with Alfio Rausa, a member of the Council on Public Information, as part of a workshop for the members of the new media spokesperson panel.



In the media spokespersons' workshop participants received on-camera training and individual critiques to develop spokesperson skills and message presentation. Ms. Clark's workshop helped prepare participants for both print and television interviews.



Rena B. Zimmerman, MD, of Meridian answers a pointed question on partial birth abortion posed by Ms. Pat Clark during her media/speech training workshop. Other members of the MSMA Media Spokesperson Panel include: Steve L. Demetropoulos, MD; Donald W. Benefield, MD; Steven C. Brandon, MD; Hugh A. Gamble, II, MD; Alfio Rausa, MD; A. Dean Cromartie, MD; J. Patrick Barrett, MD; James R. House, III, MD; Kenneth M. Davis, MD and R. Lee Giffen, MD.



During the annual Membership Party the MSMA Alliance held a silent auction to raise funds for AMA-ERF. The auction tables and easels were loaded with art, pottery, stained glass, quilts, specialty foods and crystal. Robert G. Travnicek, MD, of Long Beach checks out the contributed items.





"The King" was in full swing during the MSMA Alliance Membership Party.



Mrs. William H., III (Stancy) Gullung, chairman of the Alliance's AMA-ERF Committee, waits for Elvis to draw the winning raffle ticket for a trip to Cancun.



Past President Dr. Sidney O. Graves, Jr. of Natchez enjoys the Past Presidents' Breakfast.



Past Presidents W. Lamar Weems, MD of Jackson; James C. Waites, MD of Laurel and Mal G. Morgan, MD of Natchez at the Past Presidents' Breakfast.



Attending the MSMA Alliance Past Presidents' Breakfast were, back row, left to right: Mrs. David L. (Martha) Clippinger, 1997-98 MSMA Alliance President Mrs. George D. (Jane) Ladner, Immediate Past President Mrs. George R. (Nancy) Bush, Mrs. Dewitt G. (Peggy) Crawford, Mrs. Ben M. (Kathy) Carmichael, Mrs. Frederick E. (Martha) Tatum, Mrs. Stanley (Beth) Hartness and Mrs. Eric E. (Nancy) Lindstrom. Front row: Mrs. James C. (Jo) Waites, Mrs Edward (Jean) Hill, Mrs. William H. (Jane) Preston, Mrs. Terrell D. (Barbara) Blanton and Mrs. Billy L. (Sylvia) Walker.



The MSMA Fifty Year Club Breakfast Bunch.



The annual MSMA Golf Tournament sponsored by Medical Assurance Company of Mississippi, Smith-Vaniz & McGraw, and Ernst & Young was held at Edgewater Bay Golf Course in Biloxi. Winning "Closest to the Hole" was Dr. Jim Fuller (left) and "Longest Drive," Dr. Ed Rigdon (right). Members of the winning team (below, left to right) were: Dr. Kenneth Hines, Dr. William Wooten, Mr. Mike Cottingham, Dr. Calvin Masterson, and Dr. Greg Wood.



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MS Academy of Physician Assistants

MS Health Sciences Information Network

MS Methodist Rehabilitation Center

MSMA Benefit Plan & Trust

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United Health Care

United Healthcare - Medicare B

United States Air Force

US Army Health Care Recruiting

Whispering Pines Hospice



H. Vann Craig, M.D.

The President's Page

Restrictions and Restraints

More physicians are becoming employees or employers, rather than solo practitioners. They feel they must increasingly think and act like business people when planning the strategic running of their practices. Some business practices, however, do not fit well in a medical practice. Restrictive covenants are a case in point.

A restrictive covenant is a contract clause designed to keep a partner or employee from opening a competing business too close or too soon after leaving a practice. In a few states they cannot be enforced, yet they remain common and are the source of heated litigation between physicians. The legal profession prohibits them on the basis of interfering with the personal liberty to live where you choose.

The AMA has long had a policy discouraging, but not prohibiting, restrictive covenants. The House of Delegates has asked the AMA Council on Ethical and Judicial Affairs - CEJA - to examine and update policy on restrictive covenants, specifically as they apply to Post Graduate Training Programs. A report is expected some time this year.

In group practice situations, this issue may appear to have some relevance. Group practices, in recruiting a new partner may offer major inducements such as moving expenses, signing bonuses, country club membership, malpractice and health insurance, a ready-made patient base, and more. Outlay of funds should be recoverable, if the new partner leaves too soon, but a restrictive covenant appears to drive a wedge between the patient and the physician the patient has come to trust.

The case for restrictive covenants is understandable, but it is not desirable in a medical practice.

If you can't stand the heat (of competition), maybe you should go into the kitchen (of adding a new partner)!

Vann



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Letter to Dr. Leslie England, Associate Editor, Journal of the Mississippi State Medical Association

Dear Dr. England:

Your "Backlash" editorial prompts me to send you a piece I wrote about, "Old to New Medicine."

Try to ferment new wine in old wine skins? The skins will burst, the new will be lost, said Scripture.

New skins must be filled with fresh juice to await fermentation. But there is no guarantee that wine will be forthcoming. It could be vinegar.

The new medicine presents a paradoxical shift from the familiar to the far side, from family doctor to capitation director, from simplicity to bewilderment, from trustfulness to litigiousness, from freedom and choice to greed and enslavement, from caring face to faceless computer, from persons meeting to robotic greetings, from me and you, to me and who?

Remnants of the old solo-practice-medicine have survived, but revival is not expected. Nor should it be.

Superstition instead of science often instructed sick people. Doctors often relied on treatments of doubtful value. (New Medicine over values itself!) Home remedy was as much a part of old's armamentarian as prescriptions that pharmacists compounded.

The earlier time doctor, schooled in masculine ideology, overvalued reason, so said Mephistophles to the Lord in the first scene of *Doctor Faust* by Goethe:

"Life somewhat better might content him.

But for the gleam of heavenly light which thou hast lent him.

He calls it reason-thence his power's increased,

To be far beastlier than any beast."

Doctor/Nurse accord once cared at the bedside. For valid reasons in 1957 the American Nurses Association cut its ties to the American Medical Association. Patients have missed that vital influence for healing ever since. Mythology sheds light on how it might be restored: Theseus, hero of Athens, volunteered to battle a people-eating Menotaur, half-beast, half-human, which the powerful and cruel king of Crete kept concealed in an escape-proof labyrinth. Theseus owed his life to a loving lass, Ariadne, who handed him a ball of thread to mark his way through the maze, overcome the monster, then follow the thread to escape from it.

There are signs that "new medicine" might restore masculine/feminine polarity. More women are becoming M.D.s. Feminine wisdom has interrupted woman's patience-in-waiting and siren song to whisper a message. "Woman, do not follow your man all the way to distraction or destruction. Use your thread of love, with its nurture, its empathy, its irrationality to hold his attention and teach him a better way.

Valued institutions that help heal should continue to move toward greater masculine-feminine accord. That is humanity's best hope to contain the "mad-male-dash toward oblivion."

Pirating privateers of the health services "reform" process are now finding it necessary to try to get a bridle on the accelerating-run-away-monster, which is bloated with an endless array of medical services paraphernalia. Success isn't likely.

In their book, *The System,* David Broder and Haynes Johnson identified CEOs (chief executive officers) of HMOs (health maintenance organizations) as high-stake operatives with insatiable appetites for money.

David Gergen, editor at large, *U.S. News and World Report,* April 29, 1996, wrote: "Health care reform points to powerful new forces shaping grassroots America." He quoted *The System*: "The health care reform process shows that our mental picture of the lobbying process is badly out of date. Now it is necessary to rethink the way the system works. New breed leaders (CEOs) like Bill Grayson of Health Insurance Association of America (HIAA), and John Motley of the National Federation of Independent Business (FIB) command large armies of enormous financial resources out in the field. They mobilized Americans at the grass roots in a way never seen before. Even as the presidency has weakened, special interests continue to grow in power. They have become (hidden) crypto-political parties, unelectable and unaccountable."

They hired political-ad-operators who waged, and are waging, a perpetual campaign to insure that big business principles of managed competition, for profit motives, and CEOs of corporate conglomerates remain in control of a common-stock-strong, medical services industry.

Armed with big financial weapons they ignore these truths: Over forty million Americans have no health insurance. Health care for the people, like security for the people is a function of public trust. Privatized, economic principles are foreign to caring. First, "do no harm" is the healer's principle for all time. Empathy of one person with another creates the doubly fertile seed of the healing gift given-the healing gift received.

Corporate America now enslaves Health Care; but, we can hope that Sophia, Spirit of Wisdom, is spinning more balls of thread for women who love their men.

John Alford, M.D.(semi-retired)

The Health Insurance Portability and Accountability Act of 1996

Is a Medical Savings Accounts (MSA) the right prescription for you? If it is, act quickly. You may be one of the relatively few self-employed individuals or small business owners and employees who can have the government pay a share of your medical expenses.

The Health Insurance Portability and Accountability Act of 1996 created the Medical Savings Account (MSA). An MSA is a tax-favored account that you can use to help pay for your medical expenses.

Beginning in 1997, if you are one of the first 750,000 qualifying individuals, you will be able to establish and contribute to an MSA.

Accounts have tax benefits.

Similar to contributions, your MSA contributions are tax-deductible, even if you do not itemize your deductions. Once established, you can withdraw MSA funds to pay your unreimbursed medical expenses.

Your MSA withdrawals are tax-free, as long as they are used for qualifying medical expenses such as doctor and dentist visits, eye glasses, and prescription drugs.

If you withdraw funds for non- medical expenses, the withdrawal will be subject to income tax and a 15% penalty. The penalty does not apply if you are age 65 or over, or if the withdrawal is made because of death or disability.

Eligibility Requirements

The law allows only certain individuals to establish an MSA. You are eligible if you meet all three of the following tests:

- You are self-employed, or you work for an employer with 50 or fewer employees.
- You are covered by a "high deductible" health insurance plan.
- You are not covered under any other comprehensive health insurance coverage.

For individual coverage, a high deductible health insurance plan is one with a deductible between $1,500 and $2,250. For a family plan, the deductible must be between $3,000 and $4,500.

A high deductible health insurance plan also must not require out-of- pocket costs in excess of $3,000 for an individual or $5,500 for a family.

You can contribute to an MSA as much as 65% of your insurance policy's deductible if you are single. Family plan contributions can be as much as 75% of the deductible.

For example, if you are single with a $2,000 deductible policy, you may be able to set aside up to $1,300 per year in your MSA. Similar to an IRA, you may make your MSA contributions as late as April 15 of the following year and still qualify for a tax deduction.

Establishing an MSA

To set up an MSA, you must contact an MSA trustee such as a bank, insurance company, or other financial institution. You do not need to notify the IRS about your MSA, since that is handled by your trustee.

If you own a business with 50 or fewer employees, you may establish an MSA for each of your employees. Any contributions on behalf of your employees are treated as nontaxable fringe benefits. Also, if you contribute directly to your employees' MSA accounts, your employees may not put additional money into their own accounts during that year.

Finally, the law does not require annual contributions to an MSA, but if you do contribute, your contributions must be "comparable." In other words, you must either make the same amount of contribution for all of your employees, or the same percentage of the deductible under their high deductible plan.

[Editor's Note: Golden Rule Insurance Company and Time Insurance Company are among insurance companies offering MSAs. The MSMA Benefit Plan and Trust will also provide information about MSAs to its participants.]

This article is reprinted from the Spring '97 issue of "Financial Perspective," a newsletter of Smith, Turner and Reeves, P.A., Jackson.

Physicians Grade Managed Care

The New England Medical Center's Primary Care Outcomes Research Institute has joined the MEDSTAT Group (a sister company to the publisher of the Physician's Desk Reference) and J.D. Power and Associates to conduct the first national survey to measure physician satisfaction with health plans. The program is designed to address the lack of representation of the physician's voice in the assessment of plan performance and in the quality of care provided. While patient satisfaction is routinely measured, physician satisfaction is not. The Memphis area has been selected as one of the six sites for the initial launch of the program. A sample of physicians in the area received a survey in May. The questionnaire asked physicians about their perceptions of plans (administrative burden, authorization procedures, financial arrangements, quality of care, etc.). It also asked them about their practice styles including receptivity to managed care, involvement of patients in treatment options, etc. In return for participation, each physician receives a complimentary top line report profiling the performance of top plans in the area from the physicians' perspective.

JOURNAL MSMA Receives Crystal Award

The Mississippi Chapter of the International Association of Business Communicators (IABC) selected the *JOURNAL MSMA* as recipient of the 1997 Crystal Award of Merit in the publications category. The December 1996 issue, "From 'Doc' on Horseback to Managed Care, Commemorating the 140th Anniversary of the Mississippi State Medical Association," entry was judged on the ability of the piece to meet communication objectives, including overall content and design. Judges cited the issue as "best publication to fulfill a stated communication objective," the objective being to convey the history of the MSMA and acknowledge the progress of modern medicine. Judges also considered the magazine's impact on its target audience and professionalism in production and technique. Other issues of the *JOURNAL MSMA* were also judged as consistent quality was also a criterion.

IABC/Mississippi exists to: link members to an international network of communication professionals, provide professional development, opportunities and resources and enhance professional communication skills.

Medicaid Patients Access Specialists

Chronically ill patients participating in Medicaid's primary care case management program can now have direct access to specialty care. Medicaid officials have told MSMA that they recognize that some HealthMACS patients with chronic, disabling, or degenerative conditions can be best treated in a more cost-effective manner if treated by specialists. The direct access provision can be initiated by either the primary care physician or the specialist.

A specialist who has been treating a chronically ill patient and wants to continue management of that patient's care should send a written request to the Division of Medicaid, Managed Care Division. The request should confirm that the condition cannot be managed by a primary care physician and that the specialist will arrange for medical services as needed by this patient. This request requires review and approval by medical staff at the Division of Medicaid.

A primary care physician (PCP) who believes the chronically ill patient can be better managed by a specialist should send a letter or the appropriate form to the Division of Medicaid, Managed Care Division and request that the patient be disenrolled due to the nature of the illness. This request is then reviewed by medical staff at the Division of Medicaid. The PCP is required to include information such as the type of condition and the type of provider needed to manage the patient's care.

Photo Contest

The *JOURNAL MSMA* is seeking outstanding photographs taken by physicians for publication on the cover of 1998 issues of the magazine. We are searching for exceptional photographs taken by Mississippi physicians. The Committee on Publications will judge the entries on the merits of quality, composition, originality and appropriateness to the *JOURNAL MSMA* and select the top twelve best photos to appear on the cover. Photographs must be submitted by October 1, 1997 to be considered. Color photos will be accepted. Print size must be approximately 5 by 7 inches or 8 by 10 inches. Vertical format photos are preferred.

Send entries along with a brief description of the subject, as well of yourself, to Karen Evers, managing editor, JOURNAL MSMA, Mississippi Medical Association, 735 Riverside Drive, Jackson, Mississippi, 39202. For more information, contact Ms. Evers at (800) 898-0251, extension 412, or (601) 354-5433.

HCQIP Project Report- Findings Released in Use of Ace Inhibitors in Heart Failure Project

As part of the Health Care Quality Improvement Program, the Foundation has released the findings of a project entitled "Use of Ace Inhibitors in the Treatment of Heart Failure." Focus of the project was improving the outcomes of heart failure patients through education on the importance of evaluation of left ventricular (LV) function and the effectiveness of ACE inhibitors to reduce disability and prolong life.

These objectives were selected from the clinical guideline published by the Agency for Health Care Policy and Research (AHCPR).

To establish a baseline of information on the treatment of heart failure among Medicare patients in Mississippi, a statewide stratified random sample of 672 heart failure records was abstracted. Appropriate patient exclusions were made under guidance of a Project Study Group.

Reviewing information from these baseline charts, the Study Group recommended that the Foundation offer a project to Mississippi hospitals emphasizing both the measurement and quantification of LV ejection fraction for patients admitted with heart failure and the use of ACE inhibitors as a therapy for heart failure patients.

Fourteen Mississippi hospitals, including both large and small facilities, collaborated in the project. Several participating facilities collected their own baseline data on the key indicators (measurement of LV ejection fraction and use of ACE inhibitors) prior to starting the project. Others used the Foundation's statewide sample for baseline.

The 14 hospitals used a variety of activities for project implementation, including staff education, use of standard protocols or standing orders, patient education, internal monitoring, and development of clinical pathways for treatment of heart failure patients.

Following implementation of all improvement plans, over 1000 patient records from the participating facilities were abstracted to measure project impact.

The follow-up review revealed:

A statistically significant increase in LV ejection fraction measurement from 50.7% to 64.3%.

Documentation of numeric quantification of LV ejection fraction increased from 75.8% to 91%. The methods used to evaluate ejection fraction also shifted dramatically. Left ventriculograms decreased from 70.4% to 3.4%, while echocardiograms increased from 19.2% to 67.0% between baseline and follow-up. This change from an invasive high-cost procedure to a low-cost non-invasive test to evaluate LV ejection fraction is an important change in practice patterns.

The use of ACE inhibitors prescribed on discharge showed little change from what had been found on baseline (prior to project).

While the overall percentage of patients discharged on ACE inhibitors remained approximately the same, a significant increase, 32.2% to 40.5%, was noted in the number of patients placed on ACE inhibitors prior to admission.

Note: The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the state of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this article does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

-James S. McIlwain, M.D.
Principal Clinical Coordinator

New Members Elected to Board of Directors

Ten physicians have been elected to the Foundation's 23 member board, to begin serving two-year terms. Names were announced at the 26th annual session of the Foundation held at the Mississippi State Medical Convention in Biloxi May 15. At the meeting, Dr. Glenn Peters of Louisville was named the recipient of the A. A. Derrick Physician Award. Also at the session, Dr. James McIlwain and Dr. Alton Cobb presented updates to the membership on the Health Care Quality Improvement Program.

The following physicians were elected to the board: George Abraham of Vicksburg; Mary Gayle Armstrong of Madison; Robert E. DeCoux Jr. of Hattiesburg; Jack C. Evans of Laurel; Tom C. Fenter of Jackson; Joe C. Files of Jackson; John F. Hassell of Laurel; Braxter P. Irby Jr. of Brookhaven; David H. Irwin Jr. of Tupelo; and Eugene F. Webb of Greenwood.

The new members join 10 physicians who have another year in their terms to serve on the board. They are Leonard Brandon of Starkville, Charles Brock of Cleveland, John Cook of Jackson, Leslie England of Natchez, Hugh A. Gamble of Greenville, David Hall of Natchez, Karl Hatten of Clarksdale, Joseph Hillman of Columbus, John Paul Lee of Forest, and Kenneth Reid of Meridian.

Retiring from the board are Dr. Peters, who has served as chairman for the past year; Dr. William Henderson of Oxford, Dr. Samuel Peeples and Dr. Francis Morrison of Jackson, Dr. Tim Alford of Kosciusko, and Dr. W. R. Arnett of Hattiesburg. Dr. Morrison has served as vice-chair, and Dr. Henderson has served on the executive committee.

Serving as hospital representatives on the board are administrators Rohn Butterfield of Corinth and Wayne Harris of Mendenhall. J. L. Scott of Jackson is the consumer representative.

Physicians' Recognition Award

Thirty-nine MSMA members were named recipients of the AMA Physicians Recognition Award during the period December 1995-March 1996. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Mississippi Medical Society
Virgil Isaac Aultman, MD
William Lee Carlyle, MD
Kenneth Gilbert Carter, MD
John Philip Foster, MD
Charles Decherd Guess, MD
Michael G. Kanosky, MD
James Dennis Lee, MD
Robert Odell May, MD
James S. McIlwain, MD
Clyde Ray McLaurin, MD
Seshadri Raju, MD
Robert Smith, MD
Billy Lake Walker, MD

Coast Counties Medical Society
James C. Funderburg, MD
Roderick Gray Newell, MD

Delta Medical Society
Charlene Bell Broome, MD
Walter Cornelius Gough, MD
Robert Taylor Love, MD
Arthur E. Wood, MD

East Mississippi Medical Society
Francis E. Harman, MD
Robert Wylie Jarrett, MD
John Evans Mann, MD
Sandra Heckert Pupa, MD

North Mississippi Medical Society
Dwalia Sherree South, MD
Willie Lee Wells, MD

Northeast Mississippi Medical Society
T. David Griffin, MD
Earl Leslie Mahaffey, MD
John Henry Nading, MD
K. Scott Segars, MD

Prairie Medical Society
Leonard H. Brandon, MD
Phyllis E. Mason, MD

South Mississippi Medical Society
Marc Scott D'Angelo, MD
Willus Mark Horne, MD
Word McDonald Johnston, MD

Singing River Medical Society
Donald Edward Doyle, MD
Joseph S. Mestayer, MD
Thurman Neal Polchow, MD
Elizabeth Hurst Smith, MD

West Mississippi Medical Society
George Ellis Abraham, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**



***Dr. Candace E. Keller** and **Dr. James M. Fuller, Jr. are** shown with other members of the Board of Directors of the American Medical Political Action Committee at a recent meeting. Pictured left to right, front row are: Candace E. Keller, MD, Mississippi; Mrs. Barbara Marshall, Ohio; Wilfred E. Watkins, MD, Idaho; Grant C. Lynde, medical student, Pennsylvania; Charles L. Garrett, Jr., MD, North Carolina. Left to right, back row: Robert E. Hertzka, MD, California; Roy W. Vandiver, MD, Georgia; William Alexander, MD, Pennsylvania; James M. Fuller, Jr., MD, JD, Mississippi;* William *E. Callahan, MD, Massachusets; Robert M. Bogin, MD, Colorado; and James G. White, MD, Florida.*

Janus Kulpa, MD has affiliated with D'Iberville Family Medical Clinic in Biloxi specializing in family medicine.

Freda Bush, MD of Jackson has been reappointed to the Mississippi Infant Mortality Task Force. Her appointment was made by Lt. Gov. Ronnie Musgrove, according to Senate Bill 2461, which passed during the 1997 Legislative Session and reenacted the task force. Dr. Bush's term will expire June 30 and she is expected to be reappointed for a longer period according to a Musgrove spokesman. According to S.B. 2461, the task force is created to promote reduction in the state's infant deaths and to improve the health of mothers and infants.

Larry D. Field, M.D. of Mississippi Sports Medicine and Orthopaedic Center, recently participated in the annual meeting of the Arthroscopy Association of North America by giving a presentation at the instructional course lectures entitled "Miscellaneous Shoulder Instability."

Dobrivoje S. Stokic, MD has been named Research Associate at Mississippi Methodist Rehabilitation Center (MMRC). Dr. Stokic will establish a neurophysiology laboratory for research involving spinal cord and brain injury patients. A

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

native of Yugoslavia, Dr. Stokic earned his M.D. degree and completed a residency in Physical Medicine and Rehabilitation at the University of Belgrade School of Medicine, Belgrade, Yugoslavia. For the past five years he was at the Division of Restorative Neurology and Human Neurobiology, Baylor College of Medicine, Houston, Texas.

William S. Turner, MD, staff psychiatrist at Pine Grove Adult Psychiatry Unit, has been certified by the American Board of Psychiatry and Neurology with added qualifications in geriatric psychiatry. Turner is a member of the South Mississippi Psychiatric Group and serves as staff psychiatrist at Pine Grove Recovery Center and chairman of the psychiatry department and coordinator of adult psychiatric services at Pine Grove Life Focus Center.

Ramesh Singh, MD, neurologist, with the Internal Medicine Clinic of Laurel, recently became Certified by the American Board of Psychiatry and Neurology. Singh was previously certified as a member of the Royal College of Physicians of the United Kingdom during his practice in England. This designation is one of only three recognized by the American Board.

Lewis W. Neese, MD, a pulmonary medicine physician at Hattiesburg Clinic, successfully completed the requirement for certification as a Diplomate in Pulmonary Disease by the American Board of Internal Medicine. Dr. Neese received his medical degree from the University of Alabama in Birmingham in Birmingham. He then completed a residency in internal medicine and a fellowship at the Mayo Graduate School of Medicine, Mayo Clinic, in Rochester, Minnesota.

James W. Ervin Jr., MD, has re turned to his home town of Crystal Springs to run a new primary care clinic opened by Methodist Medical Center. The Center will help patients that have difficulty traveling to Jackson for x-rays and laboratory tests. The clinic also offers free transportation to Jackson for patients that can't be treated on-site.

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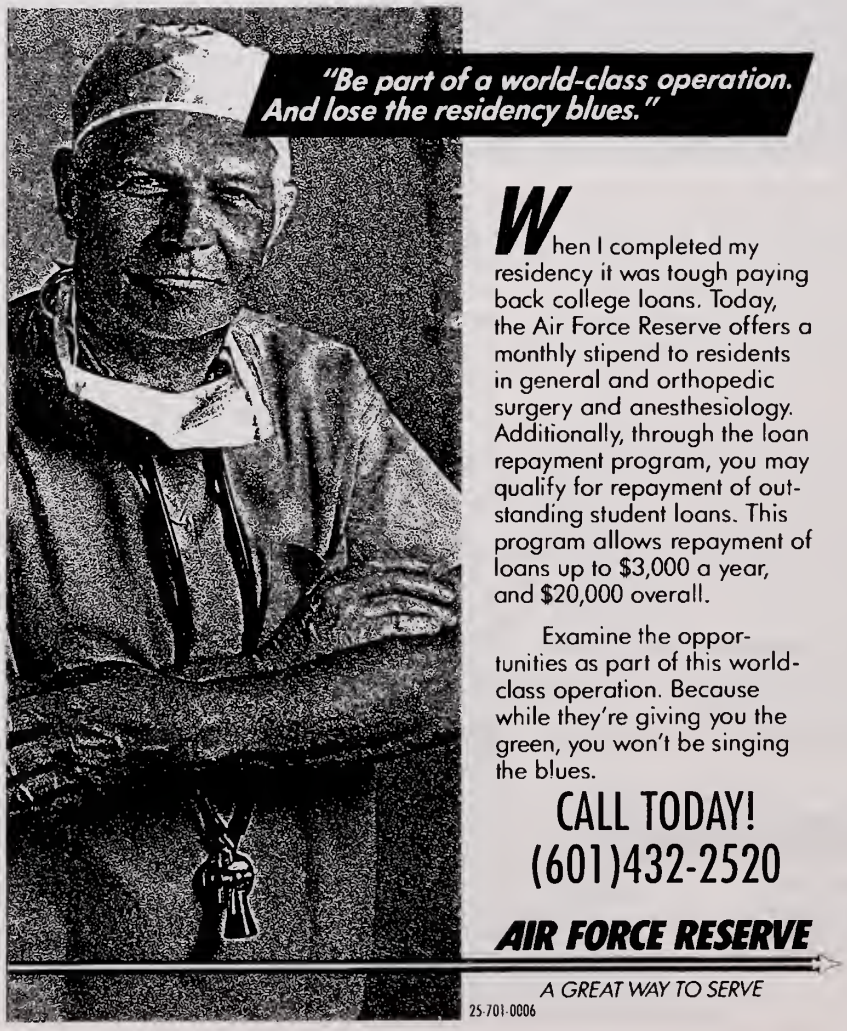
Dr. Ervin has been practicing family and emergency medicine in Amory.

Sanjay Derhgawen, MD, a nephrologist at Hattiesburg Clinic, successfully completed the requirements for certification as a Diplomate of Nephrology by the American Board of Internal Medicine. Dr. Derhgawen received his medical degree from the Patna Medical College and Hospital in Patna, India. He completed a fellowship in nephrology and hypertension at Cleveland Clinic Foundation in Cleveland, Ohio. He most recently served as the house physician of critical care medicine at Lorain Community Hospital in Lorain, Ohio. He is in practice with John M. Fitzpatrick, MD, H. Allen Gersh, MD, David I. Hirsch, MD and Philip W. Rogers, MD.

Robert Smith, MD, founder and chief medical officer of Central Mississippi Health Services Inc./ Mississippi Family Health Center Ltd., was inducted into the Jackson State University Kids Kollege Hall of Fame for his commitment to today's youth. Kids Kollege provides a range of academic and sports activities for children and youth in kindergarten through high school.

Simon Cofrancesco, MD, of Gastroenterology Associates in McComb, has been approved to conduct a study for patients with chronic hepatitis C. The study involves the use of a combination of the drugs Ribavirin and alpha-interferon. Currently, only alpha-interferon is approved by the FDA for treatment of this disease and has only been successful in a small percentage of patients treated. Dr. Cofrancesco has been approved as a principal investigator in this trial. He is a board certified gastroenterologist with a special interest in hepatology.

Mitch Massey, MD, of Tupelo Orthopaedic Clinic, P.A., has opened a satellite clinic for the practice of orthopaedic surgery at Iuka Hospital.



H. Brian Balfour, MD, has associated with Natchez Community Hospital and Natchez Regional Medical Center specializing in radiation oncology.

Larry J. Landry, MD, has associated with Robert F. Carter, MD and Charles M. Holman, Jr., MD of Biloxi in the practice of urological surgery.

Kevin Nichols, MD has associated with Randall Nance, MD, of Rural Medical Associates in Philadelphia, Mississippi.

Karl Michael Blue, MD has associated with Internal Medicine Clinic of Laurel for diagnosis and treatment of cancer.

William J. Gibson, MD has relocated his practice from Jackson to Yazoo City. It is located inside of King's Daughters Hospital.

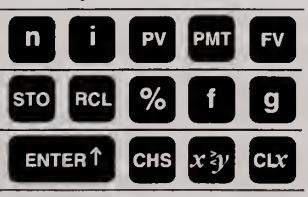
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Attention: MSMA Members

The **JOURNAL MSMA** is seeking manuscripts that have not been previously published and are not under consideration by any other publication, submitted in accordance with the guidelines for authors. Articles of medical, socio-economic nature as well as articles of local appeal relative to medical practice in Mississippi are of particular interest. Manuscripts are subject to the reviewing process by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to **JOURNAL MSMA** readers, and usefulness or importance to physicians. Authors are notified upon acceptance or rejection of their manuscript. Contact the managing editor with any questions concerning submission guidelines. Address all correspondence to the Editor, **JOURNAL MSMA**, P.O. Box 5229, Jackson, MS 39296-5229. Phone:(601)354-5433, extension 412.

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Calling All Doctor/Photographers

• Seeking photographs taken by physicians for publication as 1998 JOURNAL MSMA covers.

• Grab your camera. Shoot landscapes, people, animals, or anything else you can capture on film.

• The Committe on Publications will judge the entries on the merits of quality, composition, originality and appropriateness to the JOURNAL MSMA and select the top twelve best cover photos.

• Specifications: Color photos only.
Size: approximately 5 by 7 " or 8 by 10"
Vertical format photos are preferred.

• Deadline: October 1, 1997

Send entries with a brief description of the subject, as well of yourself, to Karen Evers, managing editor, JOURNAL MSMA, Mississippi Medical Association, 735 Riverside Drive, Jackson, Mississippi, 39202. For more information, contact Ms. Evers at (800) 898-0251, extension 412, or (601) 354-5433.

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American Medical Accreditation Program: AMA Trustee, Dr. Timothy Flaherty, Discusses the Road Ahead

What was your reaction to the debate over AMAP at the AMA's Interim Meeting?
We had an interesting discussion. The American Medical Accreditation Program, "AMAP," is extremely important to physicians. I think there had been a communications deficit, as there always is when people are getting started with a new program. Sometimes all the information people are requesting is not available. The specialty societies, in particular, had reservations and hesitations about the program, but came away convinced that AMAP was something we should move forward with on a fast track. I am pleased that support for AMAP is gaining momentum.

AMAP is a massive undertaking. Why is it necessary to move ahead so quickly?
The timing is critical. If we don't get it done now, we will lose out to the health plans, commercial vendors and other groups who are waiting in the wings to take over. If we are going to have a national acquisition of data about physicians and physician performance, it should be done by physicians; not the government, not the insurance companies. The AMA and the Federation are the best professional organizations to take on the job. With the Federation's help, we are confident we can succeed, and keep standards for physician performance in the hands of physicians.

How were members of AMAP's Governing Body selected?
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How will the Federation partner with the AMA on AMAP?
AMAP is a Federation program. Thus, the Federation will play a critical role throughout AMAP's design, implementation and operation. In fact, AMAP could not proceed without the Federation's expertise, participation, and support. For example, many state and county societies already play a vital role in credentialing and office site reviews. AMAP hopes to incorporate these existing programs and extend them to the national level so that the profession won't continue to be hassled by repetitive inspections when a single inspection will do. AMAP will result in less disruption of physicians' offices, medical records, and patient programs. It's a big plus.



Timothy T. Flaherty, MD

When will AMAP be up and running?
AMAP will be rolled out on a state-by-state basis. Massachusetts was selected as the initial implementation site because the Massachusetts Medical Society already has the necessary structural framework in place. A number of other states have volunteered to partner with AMAP in implementation of AMAP, and future states will be selected based on how far along each state is in terms of providing similar services to its members. Ultimately, AMAP will follow a natural progression adding more states and additional components as soon as feasible. We expect AMAP to be fully operational nationwide in four years.

What role will specialty board certification play in AMAP?
AMAP is a physician accreditation program. It is not a specialty board certification program. Obviously, if you are board-certified or recertified by your board, these factors will be included in your AMAP profile and should be. However, AMAP and board certification are separate programs serving separate goals. AMAP will be working very closely with the American Board of Medical Specialties and other certifying agencies so that board certification will be appropriately weighed in the AMAP accreditation decision. And, we believe the specialties have a lot to gain through participation in AMAP. They will have the opportunity to set the standards for their specialty instead of having them imposed by outside groups.

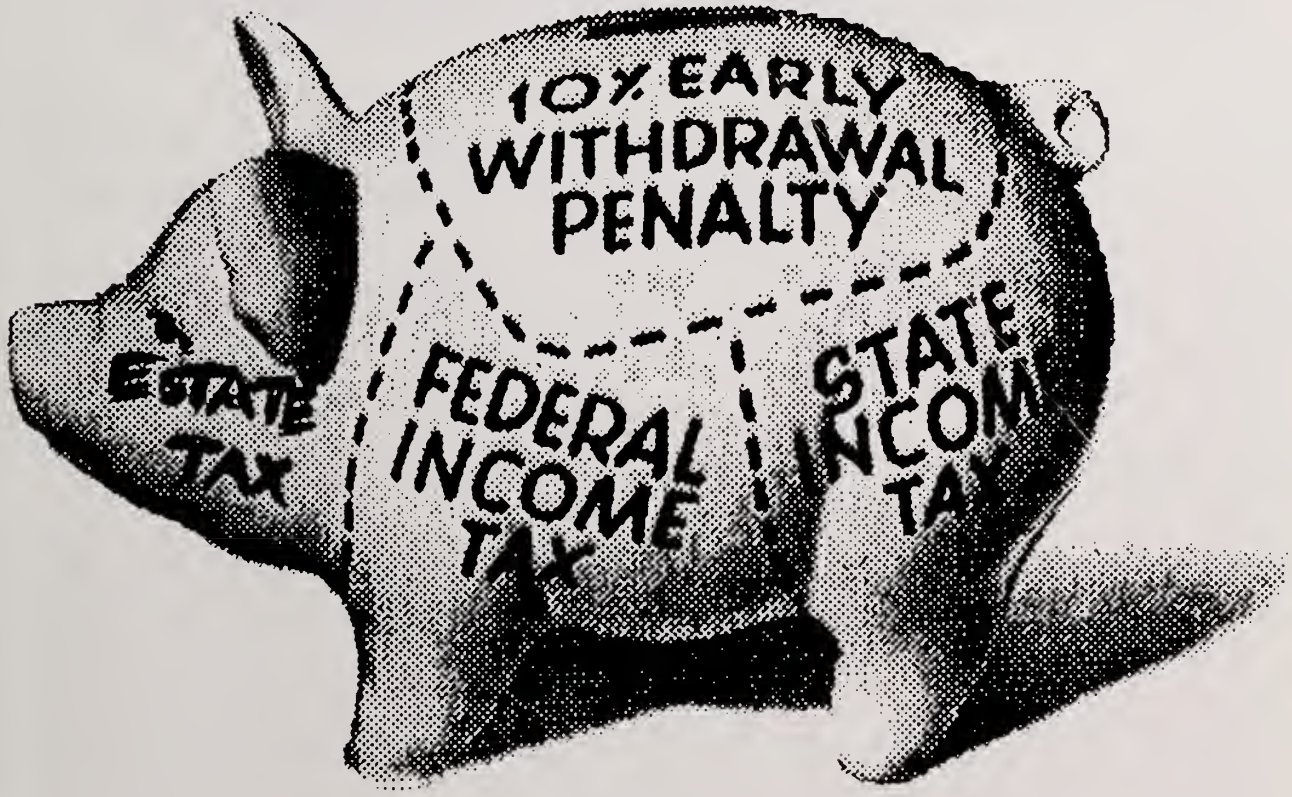
Are you confident that the House of Medicine will unite behind AMAP?
I believe medicine will unite behind AMAP–at least as much as the profession can unite behind any program of this scope and complexity. However, the commitment to the overall program is what's important. And, it will be AMAP's commitment to use Federation resources and actively involve the specialty societies which will make the acceptance of AMAP more meaningful.

You have been active in meeting with employer coalitions across the country. How has AMAP been received by them?
I serve as an advisor to the National Business Coalition on Health, and I have also been meeting with benefit managers. They could not be more enthusiastic. Benefit managers have been looking for a reliable way to identify quality. AMAP will be a big plus for them because it will provide a "Good Housekeeping Seal of Approval" that they can take to their employees and say "See, this physician, or this group of physicians, has met the highest standards of quality as established by a group of their peers."

So you believe that patients, as well as physicians, will benefit from AMAP?
Absolutely. Anytime the medical profession can establish a single, universally-recognized standard of quality, physicians everywhere will strive to meet that standard. AMAP will result in an improved evaluation process for physicians, less hassle for physicians, and improved quality of care.

Interview by Wendy Sue Morpheu, J.D.

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Drug Use and Physical Trauma:
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Coping With Cancer

Bobby L. Graham, Jr., M.D.
Sharon Martin, M.D.

INTRODUCTION

The American Cancer Society estimates that nearly 15,000 new cases of invasive cancer will be diagnosed in Mississippi in 1997. Nearly 6,000 Mississippians will die from cancer during this period.[1] Improvement in treatment and reduction in treatment related mortality have contributed to a decrease in overall mortality rates of cancer. Efforts are continuing to not only find more effective treatments, but also to improve the quality of life of patients with cancer. The field of psychooncology focuses on psychosocial aspects of cancer and cancer treatment. It addresses the patient's reaction to the diagnosis and therapy and also the roles that family, friends, and religion play in the management of this illness. We attempt to summarize some of the information that is known in the area of coping.

REACTION TO DIAGNOSIS

How a person reacts to being diagnosed with cancer in large degree is based on his or her previous experience with cancer and the meaning that society attaches to the illness. There are three phases that are typical in most patients once a diagnosis of cancer has been made. The initial period is one of disbelief and denial. Patients often seek to prove that there has been some mistake or mix-up in diagnosis. Appearing not to understand or "feeling numb" are other common reactions. A smaller group of patients may readily accept their diagnosis experiencing despair rather than disbelief in that they always expected to develop cancer. The diagnosis, therefore, merely confirms this lifelong concern. A second phase is characterized by a period of emotional turmoil and dysphoria manifest as anxiousness, depression, poor concentration, decreased appetite, insomnia, and inability to maintain daily routine. Reality slowly sets in during this phase which lasts until the patient begins treatment and realizes that all is not lost. A therapeutic alliance with the physician and staff encourages a return of optimism through cooperation with the treatment team.

The third and final phase represents the long-term adaptation in which the patient adjusts to the diagnosis and treatment, finds reason for optimism, and returns to normal routines. The quality of adaptation depends on the prior level of adjustment and emotional maturity of the patient. Coping skills that are characteristic for the individual and were useful in the past are thus utilized. It is important that family, friends and staff be aware that there is no single way to cope and to respect each individuals way of coping. Thus, to summarize this sequence, disbelief, dysphoria and adaptation is seen after the initial diagnosis of cancer and may reappear with each new crisis that occurs, such as failure to respond to treatment, relapse after a response, or significant side effects from treatment.

FACTORS INFLUENCING ADAPTATION

While the responses to diagnosis of illness may be similar, there is a wide variation of the adaptation among individuals. It is important to be able to recognize the factors which predict good or poor adjustment so that particularly vulnerable patients may be identified early on. Factors contributing to a person's adaptability are derived from three areas, society, illness, and the patient. Societal derived factors are dynamic and often influenced by public education. In today's society cancer is somewhat less feared, patients are less often stigmatized and the public is more optimistic about the ability to cure cancer. Informed consent and better knowledge of treatment options have resulted in an improved communication between the patient and the physician. However, this may result in more anxiety in that a disclosure of more information about prognosis may occur during each discussion of treatment options. This anxiety may be either increased or decreased by availability of medical information from multiple sources such as the Internet. With the use of these databases patients may become better informed and more able to participate in the treatment decisions. Finally, a negative aspect of society's view of cancer is an often held claim that stress predisposes to or causes cancer. This may result in feelings of guilt or blame on the part of the patient or family.

A second set of factors affecting adaptation are those related to the illness itself including how the cancer is known to the patient by its alteration of function, disruption of daily routines and the degree of pain or discomfort it causes. Knowledge of the stage of disease at diagnosis and the prognosis for the specific cancer may also independently effect the patient's ability to cope.

The person's ability to adapt is also dependent on his or her intrapersonal style, interpersonal resources and the developmental stage at which the diagnosis is made. The intrapersonal style refers to coping behaviors. This is defined loosely as adaptability to difficult situations which may require the development of new behaviors.

COPING

Coping draws on previous experiences, personality and defense mechanisms. Serious illness calls on coping abilities to perform several goals: to keep stress within manageable limits, to maintain a sense of personal worth, to maintain relationships with significant others and to find a socially acceptable post-illness state. A person's idiosyncratic perception of the illness often dictates the selection of the particular coping mechanisms and strategies. The most typical views of illness are as a "challenge", "the enemy", "punishment" or "weakness".

Sometimes a positive value may be placed on an illness. Previous medical experience or experience with cancer in family members or friends may shape these perceptions. Prior experience with cancer is often a negative factor, especially when it relates to childhood memories of death of a parent or sibling from cancer. Chronic hypochondriasis and cancer phobia appear more commonly following such early experiences. Death of a relative from the same type of cancer, for example, a young woman with a newly diagnosed breast cancer whose mother died of breast cancer at an early age significantly impacts coping strategies. Such a person may fear the disease more and be more likely to delay seeking treatment or may adopt a more hopeless attitude than a person whose experience with cancer has been more positive. On the other hand, individuals who firmly expect to be successfully treated will probably battle their disease more actively. Several studies suggest that this sense of control relates to the type of coping actively employed. Understanding people's beliefs about their illness is therefore an important dimension of understanding how they cope.[2]

Religious values and beliefs similarly effect coping. Research suggests that religious convictions and beliefs are associated with higher levels of self-reported well being. In a study by Yates, religious patients with advanced cancer reported significantly lower levels of pain.[3] In a recent review by Creagan, three themes became evident on the basis of a search of the literature comparing the impact of attitude and disposition on cancer survival. First, he found that among patients with cancer the biological process of the neoplasm is the most consistent factor of survival. Secondly, psychosocial-spiritual factors also modify to some extent the quality of life and possibly survival in selected patients with advanced cancer. Thirdly, social connectedness and a faith dimension are two relatively consistent characteristics among some of the long-term survivors of cancer.[4]

Interpersonal resources or social support is the second of the patient derived factors involved in adaptation to the diagnosis of cancer. There is a consistent finding that a positive relationship exists between social support and health. The quantity and availability of supports is dependent upon a number of variables, the most obvious of these being the individual's current resources. It is not likely that an isolated individual will be able to mobilize a social network more readily once he becomes ill than previously. However, it is not advisable to assume a previously well supported patient will have his needs adequately met. The person who comes from a close family and who was socially active may find that

supports fall away during illness. The disappointment and withdrawal of friends is particularly painful even if one recognizes the reasons for the response. However, the stress of illness on both patient and support provider can result in realignment of ties. A consistent theme voiced by cancer patients is a sense of surprise at the unexpected sources of support. A casual friend may emerge to provide the more intense support expected from closer family.

The impact of the disease may also effect the availability of social support. When the disease or treatment causes significant physical impairment the access to social support will be limited. The house-bound patient can quickly lose connections with others.

The emotions of the patient can effect the use of social support networks as well. Family members, friends and staff alike may find their genuine offers of support are rejected by the patient who may feel embarrassed, angered or confused about accepting help. Depressed patients tend to alienate themselves from people close to them at the times they need help the most. Misunderstanding by members of a support network about the patient's illness or needs seem to be more common among cancer patients than other populations of patients. One of the questions friends and family frequently ask is how they should offer help. Because of either their own fears or what are felt to be implied messages given by the patient, friends and family are more likely to adopt an overly optimistic attitude in dealing with the cancer patient. This stance serves to make the patient feel isolated and resentful, separated by what they feel is unrelenting optimism that seems inauthentic.

DEVELOPMENTAL STAGE

A final consideration in evaluating factors which effect coping is the developmental stage of the patient at the time of diagnosis. This refers to where the patient is with respect to the life cycle and related biological, personal and social goals when the cancer develops. Actual and potential losses have different meaning at different stages of life. In reviewing the impact of cancer at all life stages, it seems that disruption can be divided into five categories that denote major themes of stress. The first is an alteration of the interpersonal relationship or **DISTANCE.** The second is a dependent and dependence issue or **DEPENDENCE.** The third is achievement disruption or **DISABILITY.** The fourth is a body-sexual image distortion or **DISFIGUREMENT**, and the fifth is existential issues or **DEATH.** The importance of a specific disruption may vary by stage as well as by individual. Young adulthood encompasses a period of ages 19 to 30 years in which the key life cycle task centers on the achievement of intimacy and closeness to others, particularly marriage commitments. This intimacy and commitment may be hard to acheive with the uncertainty brought about with a diagnosis of cancer. In the ages of 31 to 45 the mature adult lives in a period characterized by personal growth and consolidation of career and social roles and enjoys the most stable period in the life course of a person. As the adult matures so does the family and there is now redefinition of ties to growing children and aging parents, anticipation of illness and preparation for parental death. This is a period of productivity and caring. Fundamental to this stage is confrontation with mortality, generally that of one's parents instead of one's self.

A third period is between ages 46 and 65 and is called the period of older adulthood. New family roles must be established between parents and adult children and career success usually peaks during the early years of this stage. This stage is characterized by taking care of things and people and adaptation to triumphs and disappointments. Career goals are often adjusted to conform to realistic expectations as those youthful goals are often not completely fulfilled. Many times dealing with cancer interferes with these goals, either personally or professionally, leaving only a sense of frustration rather than satisfaction.

Past age 65 is considered the aging adult. During this time the tasks include finding a balance between societal and self-involvement and making peace. Putting memories in order and coming to terms with dying are other tasks of this period. One whose emotional energies are consumed by dealing with cancer may have little left over to successfully work through these tasks.

SUMMARY

In summary, the manner in which an individual and his or her family and friends adapt to the diagnosis of cancer is quite individual and complicated, and depends on a number of factors. It is important that patients realize that they should acknowledge their feelings to their physicians, family and friends so that these feelings can be validated. In this way they can be helped to find resources to enhance their coping abilities. There are many support groups that are now available for patients in various areas of cancer treatment. Efforts are underway to bring more of these issues to light in medical training so that physicians may be better prepared to strengthen a person's ability to cope with cancer and to live to the fullest extent possible.

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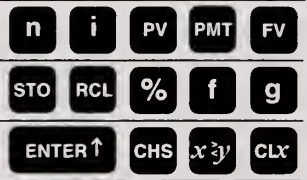
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Timothy T. Flaherty, MD

When will AMAP be up and running?
AMAP will be rolled out on a state-by-state basis. Massachusetts was selected as the initial implementation site because the Massachusetts Medical Society already has the necessary structural framework in place. A number of other states have volunteered to partner with AMAP in implementation of AMAP, and future states will be selected based on how far along each state is in terms of providing similar services to its members. Ultimately, AMAP will follow a natural progression adding more states and additional components as soon as feasible. We expect AMAP to be fully operational nationwide in four years.

What role will specialty board certification play in AMAP?
AMAP is a physician accreditation program. It is not a specialty board certification program. Obviously, if you are board-certified or recertified by your board, these factors will be included in your AMAP profile and should be. However, AMAP and board certification are separate programs serving separate goals. AMAP will be working very closely with the American Board of Medical Specialties and other certifying agencies so that board certification will be appropriately weighed in the AMAP accreditation decision. And, we believe the specialties have a lot to gain through participation in AMAP. They will have the opportunity to set the standards for their specialty instead of having them imposed by outside groups.

Are you confident that the House of Medicine will unite behind AMAP?
I believe medicine will unite behind AMAP–at least as much as the profession can unite behind any program of this scope and complexity. However, the commitment to the overall program is what's important. And, it will be AMAP's commitment to use Federation resources and actively involve the specialty societies which will make the acceptance of AMAP more meaningful.

You have been active in meeting with employer coalitions across the country. How has AMAP been received by them?
I serve as an advisor to the National Business Coalition on Health, and I have also been meeting with benefit managers. They could not be more enthusiastic. Benefit managers have been looking for a reliable way to identify quality. AMAP will be a big plus for them because it will provide a "Good Housekeeping Seal of Approval" that they can take to their employees and say "See, this physician, or this group of physicians, has met the highest standards of quality as established by a group of their peers."

So you believe that patients, as well as physicians, will benefit from AMAP?
Absolutely. Anytime the medical profession can establish a single, universally-recognized standard of quality, physicians everywhere will strive to meet that standard. AMAP will result in an improved evaluation process for physicians, less hassle for physicians, and improved quality of care.

Interview by Wendy Sue Morphew, J.D.

Drug Use and Physical Trauma: Risk Factors for Preterm Delivery

John G. Holland, M.D.
Arthur S. Hume, Ph.D.
James N. Martin, Jr., M.D.

Abstract

Objective: The present investigation was undertaken to determine the incidence of alcohol, cocaine, and marijuana use among pregnant patients who suffered any type of physical trauma and to determine if the combination of substance use and physical trauma in pregnancy has extended perinatal implications.

Methods: In this single institution, prospective patient series undertaken over 18 months, all pregnant patients who suffered any type of physical trauma were considered for study.

Results: Among 6828 live births over an 18-month period, there were 157 (2.3%) patients who reported physical trauma (insignificant = 153, minor = 2, severe = 2). Consent to screen for the presence of alcohol, marijuana, and cocaine was obtained from 85 (54%) patients with refusal by the remainder. Screening was positive in 11% for one or more substances. The perinatal morbidity and mortality for the 153 patients with insignificant trauma was 50:1000 and 20:1000, respectively, all associated with preterm labor and delivery which occurred in 21% of the patients. None of the four patients with minor or severe trauma either had a positive drug/alcohol screen or any perinatal morbidity or mortality. No maternal mortality occurred.

Conclusion: An 11% incidence of positive drug screens was encountered in consenting pregnant trauma victims and a 21% incidence of preterm birth was encountered even in this patient population with so-called insignificant trauma.

Key words: Drug use and physical trauma

Introduction

Use of mood-altering, potentially addictive substances by the gravid patient has become a significant perinatal problem in our society.[1-3] At least 33% of the United States population over the age of 12 is reported to use marijuana, cocaine, heroin, or other mood-altering substances with high abuse potential.[4] About 15% of pregnant patients who attend both public and private clinics in a neighboring state to Mississippi tested positive when tested for alcohol, cannabinoids, cocaine, and opiates.[5] Although the incidence of gestational substance use is considered to be frequent, the exact incidence is unknown.

Trauma is the leading cause of nonobstetric maternal death,[6] and accidental injuries of some type are

estimated to affect 6-7% of all pregnancies.[7] The role of illicit substance use in association with trauma during pregnancy is problematic and potentially a major perinatal concern.

The present investigation was undertaken to determine how frequently pregnant trauma victims used alcohol, marijuana, or cocaine coincident with their accidents and to determine if the combination of substance use and trauma in a pregnant patient is associated with immediate and delayed perinatal complications.

Materials and Methods

This investigation was undertaken at the University of Mississippi Medical Center in Jackson over an 18-month period between June 1, 1990 and February 29, 1992. As a part of the prospective evaluation of all pregnant patients seen in the adult or obstetric emergency area with a report of any type of physical trauma, an effort was made to obtain patient consent to evaluate urine and blood specimens for the presence of illicit substances. Following a report of trauma, all pregnant patients were evaluated by an obstetrician to determine if there were a need for further extended maternal and/or fetal monitoring.

Patients were categorized as having insignificant, minor, or severe trauma according to the protocol of Higgins et al.[8] Trauma suffered by the patient was categorized into one of three groups: MAJOR injuries included documentation of shock at the time of admission, skull fracture, cerebral contusion, or intracerebral hemorrhage, spinal column fracture, and/or a spinal cord injury, chest injury necessitating thoracotomy or tube thoracostomy, injury of the abdominal viscera or genitourinary tract treated operatively, or a pelvic fracture; MINOR injuries included all other injuries of the head, chest, abdominal and genitourinary injuries in addition to deep lacerations, long bone fractures, and facial fractures; and INSIGNIFICANT injuries involved soft tissue injuries, superficial lacerations, and fractures of the bones of the hands and feet.[8-10] Major and minor trauma in pregnant patients required evaluation by the Trauma Team in the emergency room.

Patients were admitted to the Labor and Delivery Suite for at least 24 hours of monitoring after the episode of trauma if (a) gestational age was estimated to be $\geq$ 25 weeks; (b) there was direct abdominal trauma even if considered insignificant; (c) the patient experienced vaginal bleeding, uterine contractions, or a positive Kleihauer-Betke test; and/or (d) the trauma was considered to be minor or major. Patients were not admitted if the gestational age of the pregnancy was < 25 weeks and trauma was evaluated for evidence of uterine activity, vaginal bleeding, and preterm premature rupture of the membranes. An ultrasound examination was performed to evaluate the fetus for trauma or anomalies and special care was taken to evaluate the placental area for any evidence of a retroplacental clot that would suggest placental abruption. Routinely, a prothrombin time, partial thromboplastin time, fibrinogen, Kleihauer-Betke, and drug screening (if consented) to include ethanol (blood), cocaine (urine), and marijuana (urine) were performed. If the initial Kleihauer-Betke study were positive, repeat studies were performed at 12-hour intervals until negative.

After 24 hours of continuous fetal heart rate monitoring, patients were transferred to an antepartum bed and discharged home after recovery from the traumatic insult and achievement of a negative Kleihauer-Betke screen. Fetal morbidity and mortality were evaluated in relation to the occurrence of fetal distress, the need for immediate delivery versus remote delivery, Apgar scores, and eventual perinatal outcome.

Drug screens for alcohol, cocaine, and marijuana were performed in the Clinical Laboratory of the Medical Center and the research laboratory of the Department of Pharmacology. Screening for cocaine and marijuana was performed by use of the SYVA Emit enzyme-linked immunoassays for urinary metabolites of cocaine and cannabinoids (SYVA Co., Palo Alto, CA). Maternal serum was evaluated for ethanol by utilizing the Adx Toxicology Assays -REA (Abbott Laboratories).

Results

During the 1-month study interval there were 6828 live births and 157 (0.02%) reported instances of trauma. Seventy-one (45%) of these patients reported falling, 36 (23%) experienced motor vehicle accidents, 37 (23%) patients suffered assault of one type or another, and 13 (8%) patients suffered miscellaneous injuries including one patient who slipped on a banana peel.

Only 85 of 157 possible study subjects (54%) consented to drug screening for ethanol, cocaine, and marijuana. Ethanol was positive in four patients (5%), cocaine was positive in four patients (5%), and five (6%) of the tested patients had positive marijuana screens. Both a positive cocaine and positive marijuana were noted in two patients. Thus 11, of 85 (13%) patients who were tested had a positive drug screen for one or more mood-altering substances.

The fetuses of 122 patients (78%) were monitored electronically for an extended period ($\geq$ 24 hours) of time. Sixty-three patients (51%) had uterine contrac-

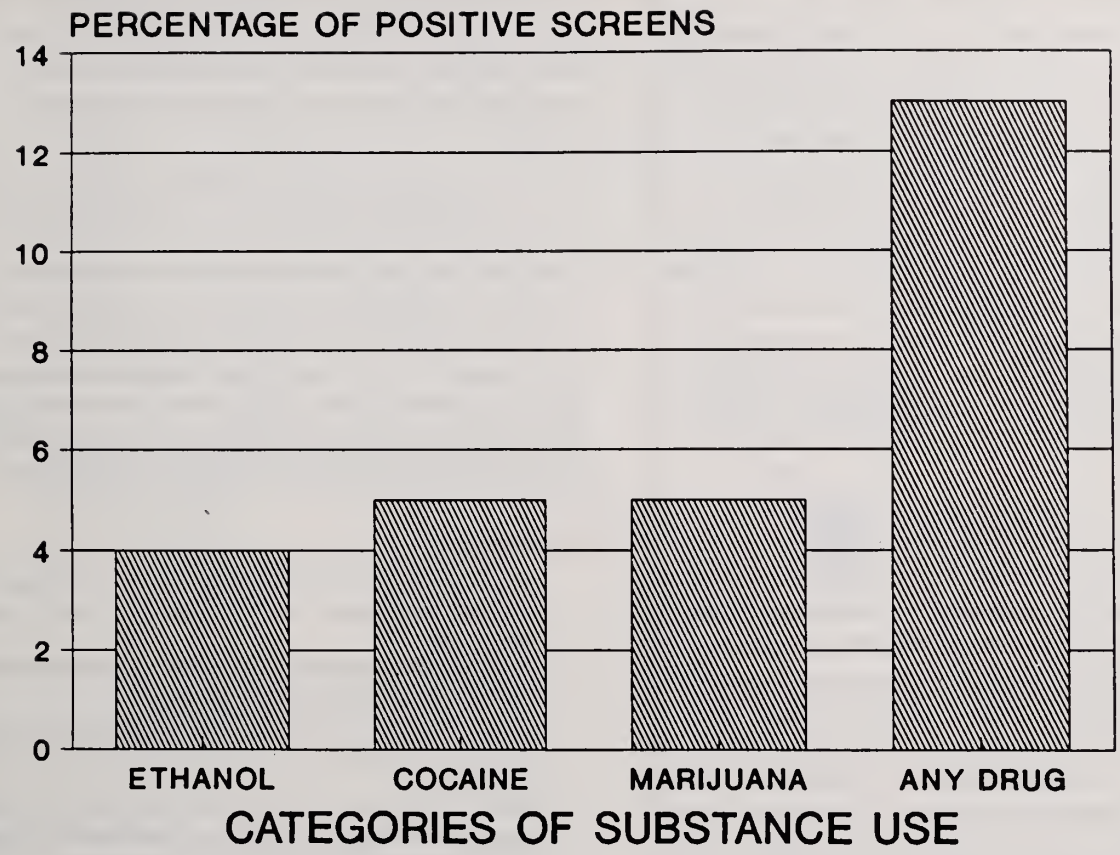


Figure 1. The incidence of positive drug screens by single type and multiple combination in pregnant patients with physical trauma.

tions demonstrated on the external fetal monitoring strip but, of these, only 15 patients (23%) required a course of magnesium sulfate tocolysis. All patients were successfully tocolyzed and discharged home. Six patients reported vaginal bleeding, two of which had a positive Kleihauer-Betke test, one developed preterm rupture of membranes, and the other two were delivered before 36 weeks.

Of the 157 incidences of trauma, 153 were rated as insignificant. This group contained all of the 13 positive drug and alcohol screens. Perinatal morbidity and mortality of this group were 50:1000 and 20:1000, respectively. All morbidity and mortality was secondary to preterm labor and delivery. Among the patients who reported trauma, 119 (76%) were delivered eventually at the Medical Center and 25 delivered before 37 completed weeks of gestation. Thus, the incidence of preterm delivery was 21%. There were two patients with minor and two with severe trauma, none of which was associated with a positive drug or alcohol screen. The associated perinatal morbidity and mortality of these four patients was zero. No maternal mortality was encountered.

One hundred twelve patients (71%) were admitted. Eleven stayed one day, 43 stayed two days, 42 stayed three days, and 10 stayed four days with an average length of stay of 2.3 days. The longest hospitalization was undertaken by a severely traumatized patient who required a 32-day hospitalization.

Discussion

Because of the well known association between trauma and alcohol or other drug use in the nonpregnant patient, we undertook this study with the anticipation that a high incidence of positive alcohol/drug screens would be encountered in association with the occurrence of maternal trauma. In a study in Fulton County, Georgia, 40% of screened homicide victims tested positive for cocaine metabolites.[11] It was surprising then when only 11% of the tested patients had evidence of recent sub-

stance use.

Although no controlled studies of substance use have been performed recently in our pregnant patient population, noteworthy findings in a neighboring state to Mississippi in which urine was obtained on the first prenatal visit showed cocaine was positive in 6-7%, and cannabinoids in 15-16%.[12] In another study with close parallels to our geography and patient population, screening was performed on patients that visited the public health maternity clinics of the University of Alabama at Birmingham. Investigators there found that 9.3% of the pregnant patients tested positive for marijuana and 1.4% tested positive for cocaine.[13] Twenty-three percent of patients who delivered without prenatal care tested positive for cocaine and 11% screened positive for cannabinoids.[12]

Recently, Pearlman and Tintinalli reviewed several studies and noted that injuries to pregnant women were most frequently motor vehicle accidents (42%), followed by falls (34%), direct assault tot he abdomen (18%), and miscellaneous causes (6%).[19] Our results differ quantitatively somewhat in that the frequency of motor vehicle accidents was only 23%, falls were 45%, direct assault tot he abdomen was 23%, and miscellaneous causes were 8% for the various categories. The relative order of frequency was similar in each investigation.

We were disappointed that only 54% of the potential patient population consented to drug testing. A higher rate of drug use likely would have been determined by global screening. Screening only for three substances might have underestimated true overall drug use in this patient population. Keith and MacGregor reported that up to 76% of cocaine users use more than one substance.[16] More extensive drug screens might have yielded supportive data for polydrug use. Little and coworkers noted a frequency of alcohol abuse with "T's and Blue's" (street name for a mixture of pentazocine and tripelennamine) of 53%, heroin of 29%, cocaine of 19%, and methamphetamine of 7%. The frequency of cocaine abuse was associated with heroin 54% of the time, methamphetamine 12% of the time, and "T's and Blue's" 12% for the time.[17,18] Thus, it is possible that a screening program which included barbiturates, amphetamines, and opiates might have identified more patients.

We believe that broad-based drug screening should be undertaken routinely for any pregnant patient who has recently suffered a traumatic event of whatever type. The presence of a positive screen should be corroborated with definitive drug identification and the patient should be evaluated for the presence of sexually transmitted disease, chemical dependency, and possible social services evaluation of the home and family environment. Identification of the pregnancy "at risk" for perinatal morbidity and mortality associated with drug use should lead to more intensive perinatal surveillance throughout the remainder of the antepartum, intrapartum, and postpartum course.

The 21% incidence of preterm delivery in this patient population with trauma even of the insignificant type suggests that the occurrence of an episode even of "insignificant" trauma should initiate a comprehensive, ongoing evaluation and management of the pregnancy thereafter as high risk. Drug screening could be a part of this assessment. Further study of pregnancy outcomes from a larger investigation might yield useful information helpful in the construction of suitable practice guidelines appropriate to these special maternal-perinatal pairs.

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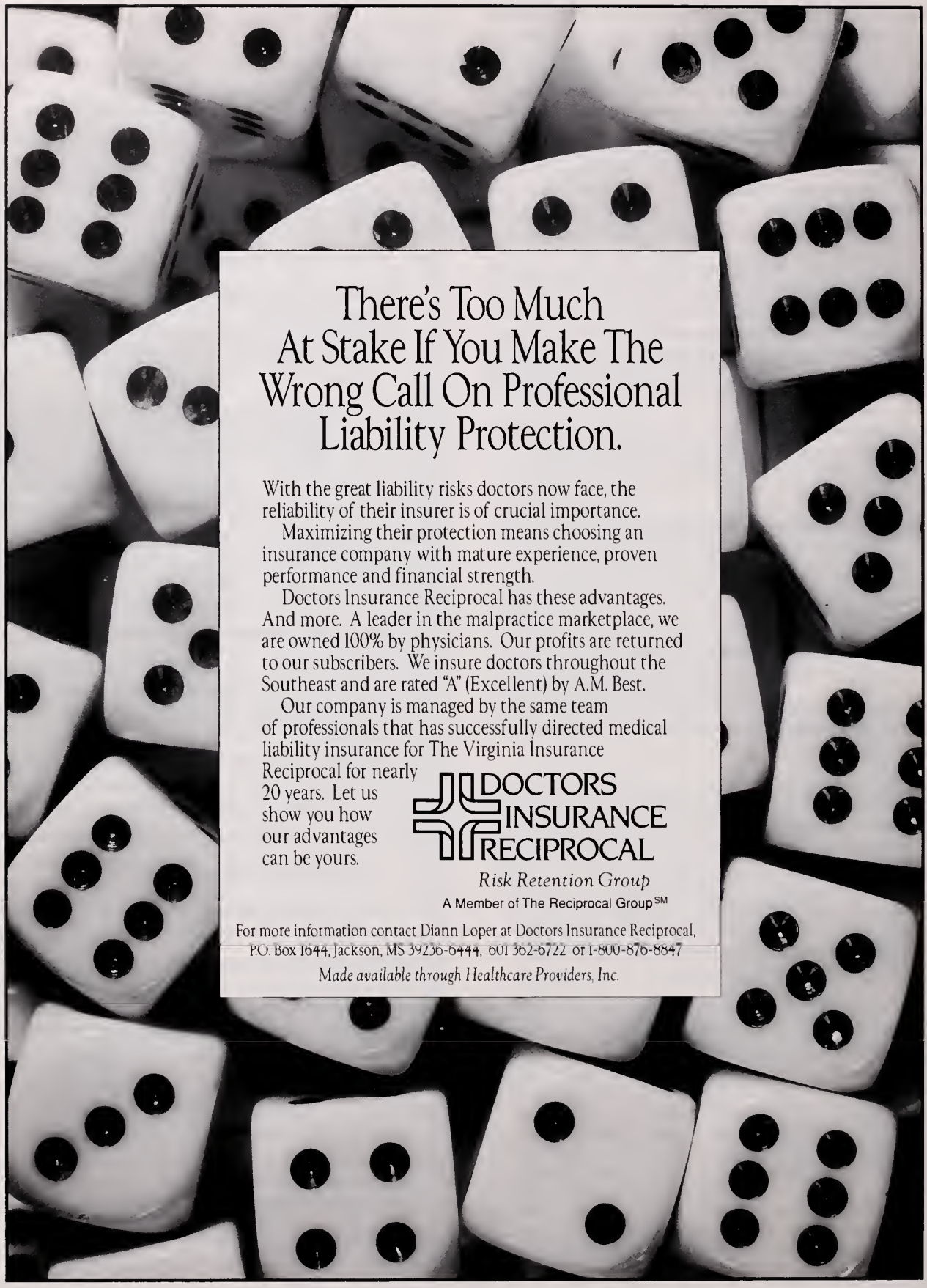
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H. Vann Craig, M.D.

The President's Page

Doctor, Can You Help Me Out?

The Supreme Court of the United States has seen fit to review the question of physician assisted suicide brought to it as two cases from New York and Washington. They have decided that there is NO constitutional right to physician assisted suicide by a 9-0 vote!

Australia's Northern Territory Government introduced "The Rights of the Terminally Ill Act" in July, 1996. It passed their Parliament on a 13-12 vote and four people killed themselves with a physician's help before this law was overturned by the National Parliament by a vote of 38-33. The Australian Medical Association has expressed regret over the manner of these deaths.

Physician assisted suicide is not in the best interests of American medicine. It negates the very essence of our profession. The AMA has come down hard on the side that it is unethical to deliberately and actively cause the death of a patient. If treatment with anti- depressants and analgesics cause, as a side effect, respiratory depression and subsequent death, that is a different situation. Physicians hate to say no to patients and families. We may be drawn into the home health / durable medical equipment scenario and step on the "slippery slope" of active euthanasia for those individuals who have not or cannot make a decision for themselves as has occurred in the Netherlands. There, 59% do not report their cases of euthanasia and 50% feel free to suggest this form of death to their patients. Also, 25% admit ending their patients lives without their consent. Thus it appears that the "slippery slope" is a very real thing.

The answer to the question above is, "Yes, I can help you out but I will not help you OUT."



Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 8
AUGUST 1997

Just Who Are We Anyway?

In the April issue of *Journal MSMA* Dr. Arthur Eugene Wood, Jr. stated in his letter to the editor. . . . "In my area (the Delta) prescriptions written by nurse practitioners are given the title of doctor in front of their name by the pharmacy."

Dr. Wood cited some other areas of confusion and concluded his letter by asking . . . . "I wonder if any other physicians have noted this and are they concerned or unhappy with it?"

Dr. Wood's question was referred to the Council on Medical Services. The Council saw an excellent opportunity to appropriately punt this to the Joint Practice Committee who took up the issue. Quickly this group came to the conclusion that labeling the title of "Doctor" on a prescription bottle written by a nurse practitioner was an inappropriate practice and one not desired by either the physician or nursing groups.

It was further decided to report these findings and the committee's recommendations to the Board of Pharmacy for their action.

I'm sure the labeling will be modified in the future, but we all know the wheels of change roll rather slowly. Currently, you may typically see on your patient's prescription labels. . . "Dr. Jane Doe, F.N.P." This happens either because hand-typed pharmacy labels are preprinted "Dr. _____" and so, I suspect, are the computer-generated kind.

This practice obviously adds to the confusion of the patient because the great majority of them already refer to Advanced Practice Nurses as "that Nurse-doctor lady I saw while you were gone on vacation." The nurse practitioners do not encourage this, patients simply don't know any better. And most of them certainly don't have a clue about what F.N.P. stands for. (Fairly nice person??? Fine new physician???)

In a recent article in *Medical Economics*/ (May 12, 1997) "Internal Medicine's Identity Crisis," Dr. Christine Cassel, past-president of the American College of Physicians said, "Internal Medicine is the largest specialty in the United States, yet the public doesn't know what an internist is . . . American College of Physicians' research showed . . . only 25 percent (of Americans) correctly identified internists as specialists in internal medicine. Another 25 percent believed that they were "interns" or "just out of school."

Dr. Cassell's article also explained that Managed Care Organizations didn't seem to understand what the specialty of Internal Medicine is all about either. . ."They tend to draw artificial lines between general and specialty care. HMOs make you choose between being a primary-care physician and being a hospital based subspecialist, when many (internists) want to do both . . . Those who choose primary care often feel that they are being "devalued" by being paid the same as F.P.s (Family Practitioners). "

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

As a result, the American College of Physicians is launching a three-year $5 million "national identity campaign to raise public awareness about what internists are: doctors for adults. The campaign may presage a name change for the specialty."

The pharmaceutical companies are confused with us, too. Between April 28 and May 9 I conducted an informal survey of the "drug reps" (pharmaceutical detail persons) who came to my office to leave samples, dispense information and generally give me a nice 5 minute break. Thanks to the Dingle Bill each "drug rep" is now required to get the physician's signature on a form verifying that he actually received a certain number of samples at that visit.

Several months ago I began to notice the space where I was signing never or was rarely ever denoted "doctor's signature." Thus began my survey. During those two weeks I saw 20 detail people and my signature was given 10 different labels. The results were:

Physician's signature	3
Provider's signature	2
Practitioner signature	3
Professional's signature	2
Physician/Healthcare Provider signature	1
Physician/Practitioner signature	1
Licensed Practitioner's signature	3
Approved licensed practitioner's signature	2
Authorized signature	1
Sign by X	2

So much for my very technical foray into the field of research. The drug companies should win some sort of award for their attempts at political correctness.

Various trade and lay medical journals sometimes also exhibit a vacillating approach. Recently in a publication called *Menopause Management* the author of a basically excellent article "Enhancing Your Sexual Response, variously referred to "Your health professional," "Your provider," "a caregiver," and "Medical Specialists." I guess the writer decided that "physicians" could not be depended on to help women enhance their sexual response, but that some angelic "caregiver" would be delighted to demonstrate Kegels for the unfortunate unfulfilled.

The pharmacists, pharmaceutical companies, managed care organizations, medical writers and patients are no longer certain who are physicians these days.

Some of their confusion stems from efforts to be politically correct and some from simple ignorance. These things we can deal with.

What we seem to be having the most trouble with is self-definition. There were many thought provoking issues discussed at the recent annual session of MSMA. One discussion centered on the apparent lack of interest in attending local and component medical society meetings. Some members who smilingly label themselves the "old grey-heads" talked about what local medical society meetings used to be like . . . physicians of every specialty type within a certain geographic locale periodically meeting together for a social hour, meal and fellowship. Sure there were friendly rivalries, but members came anyway, met on common ground and often times ironed out differences as gentlemen and ladies within the context of a collegial environment. And best of all we learned from each other. A physician within the group might speak on a subject he'd been recently interested in or give a thought-provoking case presentation. For example, a local ophthalmologist member might speak for 20 minutes on "Retinal Disorders and Recent Advances in their Treatment." The rest of the group, regardless of specialty, all having a similar background in "Guytonian Physiology" could glean something from it. The speaker would in turn become better known and appreciated in his community.

But no pharmaceutical company is probably going to chip in for that sort of passe' thing. That's why we have to sit through yet another bleak slide show on lipid-lowering agents or calcium channel blockers. Then there comes yet another out of town authority to drone for 30 more minutes about managed care organizations. Everybody has got something to sell these days. (Pardon me while I yawn.) No matter how good the steak is, doctors will only sit through that so many times. Consequently, many stay home and watch cable T.V. or surf the Internet.

Do you see what's happening? There has been a big decline in promoting the profession of medicine and a big increase in promoting the business of medicine. And it's beginning to show.

At the MSMA meeting in Biloxi, Dr. Al Rausa brought a resolution before the House of Delegates to ask that we seek to define the **"Common Thread,"** the unique qualities that bind us together as a nation of physicians, to ask the AMA to "reorganize, restructure, rebuild and revitalize organized medicine based upon what is defined to be the **Common Thread."** We later learned that there is already a task force within the AMA that is seeking to do this at the national level.

I suppose the driving force behind that Federation study group is the hope that the AMA will learn why the average person loves and respects his own personal physician but detests doctors in general. I expect we already know the answer.

In a speech to the Medical College of Virginia in December of 1950 George W. Merck said, "We try to remember that medicine is for the patient. We try never to forget that medicine is for the people. It is not for the profits. The profits follow, and if we have remembered that, they have never failed to appear. The better we have remembered it, the larger they have been."

No 5 million dollar campaign, nor even a 5 billion dollar public awareness campaign, is going to improve our image in the eyes of Americans as a whole. This will not be accomplished by spending mega bucks on glossy double page spreads in *Time* magazine, but rather by individual physicians spending more "real time" with common everyday folks (i.e. patients) and being more visible and active in our own communities.

We will heal ourselves only through healing others.

The Common Thread

Every physician is different.
Yet each physician shares much in common.
We have the same dreams. . .
of a safer saner world,
of healthier children,
of a brighter future.

We share the same hopes. . .
to fully understand the human condition,
to lessen suffering,
to truly become healers.

We share the same needs. . .
for the love of our family,
for the respect of our community,
for kinship with other physicians.

Each physician enriches the lives of his patients with his own unique talents, abilities and wisdom.

These are the Common Threads that bind us together as physicians.

-Dwalia S. South, M.D.
Associate Editor

Editorial

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ATV Accident Rate Still Unacceptable

Approximately fifteen years ago a number of physicians reported the alarming statistics relating to all terrain vehicle accidents. The number of serious injuries and deaths had been steadily increasing for several years. This concern led to subsequent government intervention, and regulations, in an attempt to curtail such costly accidents. The ATV industry pledged to pursue safety in design and manufacturing, and to emphasize safety education for the purchaser. It was expected that the rate of serious abuse and injuries would decrease. This has not been the case. The number of serious injuries and deaths secondary to misuse of ATV three and four wheeler vehicles is still unacceptable. Why are these injuries still occurring?

Manufacturers of these vehicles have followed through with a safety education program for the initial purchaser of these machines. Written and video instructions are dispensed and warning labels are attached to the vehicles. However, for such actions to be successful the purchaser must be receptive to these efforts, and interested in the safe use of the vehicle. Unfortunately, I perceive this as the weak link in the safety chain. I have witnessed a number of individuals who exhibited no interest in the safety instructions offered, and surely never reviewed the video safety instructions for safe and proper operation of the vehicle. I perceive this as a very common occurrence. One also has to wonder how much safety information gets passed on to children of those purchasing the vehicle, and to secondary buyers. Gross misuse of this type vehicle, especially by children, sends a strong message that they have not been properly instructed and are poorly supervised. It is difficult to understand why a large number of adults in this state continue to abuse, and misuse, these vehicles, yet it is even more difficult to understand why they show a total lack of responsibility, and parental concern, over the use of ATV equipment by children.

Other factors are also involved. At the same time the manufacturers are attempting to dispense safety information they continue to produce larger, more powerful, and faster vehicles. To enhance sales television advertisements present the spectacular use of ATV vehicles. We see exotic mountain excursions, fording of gullies and streams, and radical driving in the desert environment. We now have a class of vehicle racing utilizing ATVs. Such events may be safe for the properly instructed driver participating in a well supervised event, and wearing the proper protective equipment. The problem occurs when the child, or adult, attempts to mimic these activities in the unsupervised setting, and without proper protective gear. This leads to frequent injuries that can be very costly and disabling.

With the death and injury rate equal to, and possibly above that seen in boating activities in the state, one has to ask why there is such little interest in this problem? Is it because the activity most frequently takes place on private property and not in the public arena, as does much of the boating activities. Surely it is a problem that deserves some concern by the medical profession and public health officials. Some form of mandatory safety education such as hunters safety program, or boaters' safety courses may be needed to correct this serious problem.

-Myron W. Lockey, Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



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To medical doctors and lawmakers:

Too many people feel trapped or enslaved by a monestrous kind of new medicine, which corporate America has foisted on the country, apparently with the blessings of Congress who never got around to passing major reform laws. Is true reform of our nationwide, health industry's complicated mess possible?

Health care needs someone with the courage of a Martin Luther to nail tenets for reform to the doors of Congress, The White House, and the American Medical Association (A.M.A.). Complex problems are multiplying because of the rapid rise of greedy, farflung HMOs which based reform on privatized, micro-economic tenets.

Lawmakers are, or should be, healers. Here are healing guidelines for "new medicine" that too many money-making, medical doctors forgot.

High technological diagnostic and treatment practices tend to create more problems for "the people" than more hi-tech can or will solve.

Like military security for the people, health care for the people is Public Trust; and health legislation should be enacted to insure it. The Congress must recognize that new public health laws are needed to provide for universal primary health care. Provisions for over-advertised, oversold, overbought, overused, and overvalued health services practices should remain functions of private industry and its market place.

"The heart and soul of medicine is the doctor-patient relationship," said Dr. Koop. Isn't the heart and soul of politics the greater good for all the people?

State medical associations and the A.M.A. must recognize that only dedicated humanitarian physicians can restore a disarrayed practice of medicine, to become once again a valued institution for humankind.

Individually and collectively, the people can believe and know that healing is a gift, given to each and to all, and can continue to hope that enough lawmakers will become healing instruments that help reform health care.

Person-to-person dialogue creates the doubly fertile seed of healing gift given, healing gift received.

John Alford, M.D. (semiretired)
Ocean Springs

Send Items for the
Comments Column
to the Managing Editor,
***Journal MSMA*,**
PO Box 5229,
Jackson, MS, 39296-5229

Dear Editor:

I've been remiss in telling you how great the December 1996 issue of the *JOURNAL MSMA* was. You did a great job and I really enjoyed the illustrations and reading the MSMA's history. Also, I just love the cover!

Best regards,

Allen J. Podraza
Records and Archives Manager
American Medical Association



Dear Editor:

Congratulations on being an Award of Excellence winner in APEX '97, the ninth annual awards program recognizing excellence in publications work by professional communicators. The *JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION* was among the top three most outstanding publications in the category of "One Person-Produced Magazines, Magapapers and Journals."

APEX Awards are based on excellence in graphic design, editorial content and the ability to achieve overall communications excellence. APEX Grand Awards honor the outstanding works in each main category, while APEX Awards of Excellence recognize exceptional entries in each of the subcategories.

With nearly 4,200 entries, competition was intense.

Fifty Grand Awards were presented to honor outstanding work in each of 12 major categories, with 254 Awards of Excellence recognizing exceptional entries in most of 88 subcategories.

The panel of judges for APEX '97 included John De Lellis, *Concepts* Editor and Publisher; Bill Londino, Consulting Editor of *Writing That Works* and Dr. Paul Fisher, *Concepts* Senior Evaluator and formerly Professor of Journalism with the University of Missouri School of Journalism.

Please accept our thanks for participating and our best wishes for continued success.

Cordially,

John De Lellis
***Concepts* Editor & Publisher**

National Resident Matching Program Changes Math to Refine Match for Nation's Medical Schools Positions from the Applicant-Proposing Algorithm

Beginning in November, 1996, the National Resident Matching Program (NRMP) distributed the report widely to residency applicants, medical schools, and graduate medical education program directors for review and comment on the study results. The vast majority of the comments received by the NRMP board favored the change to the applicant-proposing algorithm.

The National Resident Matching Program was established in 1952 to provide a mechanism that would end the chaotic state of applicants and programs being forced to make commitments before all options could be considered. In addition, the program provides a common time for the announcement of the appointments, as well as an agreement for programs and applicants to honor the commitment to offer and accept an appointment if a match results.

At the University Medical Center (UMC) the 1997 Match was successful for 85 percent of the senior medical students who got their first or second choice. Forty-nine of the seniors will stay at UMC for residency training, and 41 will go to one of 17 other states.

Senate Majority Leader Says Medical Tort Reform Possible This Year, Supports $250,000 Cap on Pain and Suffering Awards

Senate Majority Leader Trent Lott voiced his support for a $250,000 cap on pain and suffering awards in medical malpractice cases at the annual meeting of the Physician Insurers Association of America (PIAA) in New Orleans.

The senator also expressed his support for "serious limits on punitive damages" and a "loser pays" provision to discourage frivolous lawsuits.

Senator Lott said medical liability reform legislation could be passed within the next year. He noted that Congressman Bill Thomas (R-CA) plans to introduce medical liability reform legislation.

"If we can't pass medical liability reform as a free standing bill, we may fold it into the reconciliation bill so it can't be filibustered to death," the Senator said. "If the medical profession, the dental association, if all the professions, and the corporate world really pitch in and help pass overall tort reform, we can win on these issues."

Clinical Guideline Clearinghouse

HHS Secretary Donna E. Shalala has announced plans to develop a comprehensive Internet-based source for clinical practice guidelines. The new National Guideline Clearinghouse (NGC) will make available a full range of current guidance on treatments for specific medical conditions.

Under the plan, HHS' Agency for Health Care Policy and Research, the American Association of Health Plans and the American Medical Association will work jointly to develop the new guideline clearinghouse. It is anticipated that AHCPR will award a contract later this year for the technical work to establish the NGC.

"Internet technology makes it possible to provide the rapid access to the latest information on medical treatments," Secretary Shalala said. "This clearinghouse will help professionals and patients alike to benefit from the growing volume of clinical practice information."

The target date for launching the new Internet clearinghouse site is Fall 1998.

"The NGC will make clinical practice guidelines available to every physician, health plan, provider, purchaser and consumer who can use a computer," said AHCPR Administrator John M. Eisenberg, M.D. "It will provide access to the widest selection of guidelines available from public and private organizations by establishing an independent, interactive Web site, accessible by using any standard Web browser or through the Web sites of our three organizations."

The development and use of clinical practice guidelines have grown markedly in the past five years. However, many existing and potential guideline users have difficulty gaining access to and keeping abreast of the many clinical practice guidelines currently in use. In addition, existing guidelines often differ in their development and content, further complicating their use.

To help address these issues, the NGC Web site will:

- contain standardized information for thousands of guidelines such as title, sponsoring organization, author(s), and methodology used;
- provide guideline abstracts, and where possible the full text of guidelines;
- compare and contrast the recommendations of guidelines on similar with one another on guideline development, dissemination, implementation and use.

Rx Remedy Survey of 30,000 Shows Strong Support for Right-To-Die Legislation But Reveals Concerns About Abuses- Final Results Highlight the Roles Religion, Age and Pain Play

As America waited for the United States Supreme Court to release its landmark ruling on the right-to-die issue, 30,000 Americans age 55 and over had already offered their opinion on the subject, thanks to an in-depth study by Rx Remedy, Inc., a leading information company specializing in the health concerns of people 55 and over, America's fastest-growing age group.

This is the first-ever national study of the age group most likely to face this ultimate issue. The results show strong across-the-board support for right-to-die legislation. But respondents also voiced concerns about the potential for abuse--for instance, whether some insurers and hospitals might quietly use euthanasia to reduce the cost of caring for terminally ill patients. Here are other highlights of the provocative 44-question survey:

•65% of the 30,000 mature Americans surveyed agree that the terminally ill should have a legal right to commit suicide with a doctor's assistance, and 64% favor enacting legislation to give people this right.

•Atheists are the strongest advocates for the right to die. Catholics are the least inclined to take this ultimate step if terminally ill. Specific percentages by religion of those who support the right to die in the 30,000-person survey: Atheists-96%; Jews-88%; Protestants-68%; Catholics-50%.

• As Americans get older, support doesn't waver. 64.7% of people ages 55-65, 64.8% of those 66-80 and 65.9% of those over age 80 support right-to-die legislation.

• 57% agree that more attention to pain control could virtually eliminate the need for euthanasia, and 78% agree that it is acceptable to give patients high doses of pain-control drugs (such as morphine), even if it hastens death.

•53% agree that physicians should be allowed to give people instructions on how to end their own lives; 33% disagree. But a full 90% agree that doctors should be allowed to withhold life-sustaining measures at the direction of a patient, proxy or living will; only 5% disagree.

• Religious beliefs are somewhat more of an obstacle for men than women: 43% of male respondents (vs. 39% of female) say their faith would prevent them from considering suicide for themselves. Even more men, 48% (vs. 43% of women), say faith would prevent them from helping a terminally ill friend commit suicide.

• Support for physician-assisted suicide is weakest in the Midwest and Deep South. Yet overall, 46 states had 50% or more respondents who supported the right. Interestingly, support was strongest among respondents in the nation's capital--72% of respondents in Washington, D.C. say it should be legal.

As for concerns about abuses, the survey elicited dozens of letters. Following are some excerpts:

A NURSE OF 30 YEARS WRITES: "Doctor-assisted suicide will become a means of disposing of unwanted people. How soon before insurance companies, Medicare and Medicaid will refuse to pay for extended care?"

ANOTHER NURSE WRITES: "Like all things in government, loopholes will allow people to kill elderly relatives or others under the guise of 'she/he is terminally ill.' Unfortunately, greed is in all professions and I include the medical profession."

A MAN FROM MICHIGAN ASKS: "Who has not experienced periods of deep discouragement, anguish and depression? Are we all to call it quits when that happens? What if Franklin Roosevelt, Itzhak Perlman or Beethoven had given up when physical calamity struck? Many greedy relatives (or even well-meaning ones) try to coax an aged or ailing relative to end it all, saying things like, 'They have lived their lives, haven't they?' I say 'No, no, no.'"

[These findings are the first results from a comprehensive study undertaken by Rx Remedy, Inc., a five-year-old health-information and database-marketing company. The firm has invested $20 million in building an unparalleled data warehouse about the health practices, attitudes and behavior of American consumers in more than 1.2 million 55+ households. The 44-question survey was distributed to households in the company database through its consumer link, ***RxEMEDY*** *Magazine. Over 100,000 households returned the surveys, many with impassioned letters based on personal experiences. From this response base, 30,000 surveys were selected and tabulated to create a demographically balanced national sample. All sample respondents are age 55 or over; the median age is 71.]*

Physician Impairment and Health: A Brief Overview

Larry S. Goldman, MD

In 1972, the American Medical Association's (AMA) Council on Mental Health published its report,[1] "The Sick Physician," drawing the profession's and the public's attention to the problem of impaired physicians. The report noted that numerous articles had appeared in the medical literature during the preceding 15-20 years suggesting that substance abuse (including alcoholism), other mental disorders, and suicide were significant health problems among physicians. This AMA report called for (1) all physicians to take responsibility for impaired colleagues, (2) the referral of impaired colleagues to appropriate committees or boards in order to obtain treatment and to protect patients, (3) educational programs for medical trainees about these problems, and (4) the development and implementation of model legislation for states in dealing with impaired physicians.

Although "sick doctor statutes" were already on the books in Florida (1969) and Texas (1971), this report catalyzed a period of increased legislative and regulatory activity. It also led to the establishment of new programs to assess, treat, and/or monitor impaired physicians; new course offerings in medical schools and residencies to educate trainees and to attempt to "inoculate" them against this occupational hazard; and additional research to clarify the nature, risk factors, course, and outcomes for impaired physicians.

During this time (1970's and early 1980's) most of this activity was focused on alcoholism and other substance abuse, and the emphasis was on physician impairment and recovery from these substance use disorders after they had already taken their toll. Eventually every state had developed some program to deal with affected physicians, and as more physicians came (or were sent) forward into these programs, more clinical and epidemiologic information began to accumulate.

First, subsequent studies of addiction rates among trainees and practicing physicians suggested that overall, physicians' misuse of substances was not necessarily greater than that of non-physicians of comparable age and other similar demographic factors.[2,3] While rates of abuse of prescription drugs seemed to run somewhat higher, rates of illicit drugs were quite a bit lower.[4] Secondly, there was a growing appreciation for the occurrence in physicians of other mental disorders, particularly depression and bipolar disorder. These conditions were seen both as co-occurrent with substance use disorders or simply by themselves. Finally, there were other conditions which caused impairment that were not mental disorders or at least which did not fit well into standard psychiatric nomenclature. In the first group were physical infirmities, including cardiac, musculoskeletal, neurologic (stroke, MS, blindness, etc.), and other conditions.[5] The second category consisted of behavioral problems such as sexual exploitation of patients or abusiveness towards patients or co-workers.[6]

Many impaired physician programs were developed in conjunction with state medical societies. In some cases this was simply a small, voluntary committee of society members, but certain states began to develop more extensive programs with a professional staff and even medical directors. An ongoing tension has been the relationship between these programs and the state licensing boards.[7] The licensing boards, which are charged with a primary mission of public protection, have sought to know as much as possible about any cases of physician illness or impairment. Some states have created "diversion programs," which allow physicians to be referred to health programs without having to be reported to their state licensing

boards. States with those arrangements have generally found that they are able to get more physicians to enter treatment voluntarily, often at earlier stages of their illnesses (i.e., before they were so impaired they did something to warrant licensing board reporting or action).[8,9]

As these programs came to enjoy the trust of their licensing boards and of physicians, the scope of types of cases coming to the programs increased. This expanded clinical demand — along with the research findings mentioned earlier — has led the field to a shift from substance abuse and impairment to broader consideration of disorders of all types and incorporation of disease prevention and health promotion.

As the field of physician health has continued to evolve, there has been an ongoing need to disseminate new information about clinical practice, program development, and regulatory issues to practitioners, administrators, and educators. One forum for this dissemination has been a series of international conferences held every 1-2 years which are co-hosted by the AMA and the Canadian Medical Association. These three-day meetings, alternating between US and Canadian venues, generally bring together 300-400 people, mostly from North America and Europe, with an interest in physician health. The most recent conference was held February 7-10, 1996, in Chandler, Arizona. The conference included half-day updates (institutes) on psychiatry, substance abuse, and women's health, as well as five plenary speakers who discussed topics as diverse as women in surgery, spirituality, medical students, the Americans with Disabilities Act, and population-based medicine. Presentations were held on stress in medical schools; managing medical and psychoactive drugs in recovering physicians; intervention strategies for physician health committees; monitoring physicians with personality disorders; fund-raising for physician health programs; national efforts to assist impaired physicians; and the effects of the "health care crisis" on physicians' emotional health, among others.

The next such conference will be held April 29 - May 2, 1998, in Victoria, British Columbia, Canada. The theme, *Managing Our Own Care: Surviving the Health Care Revolution,* will emphasize the effects of the changing health care delivery system on physician well-being. The call for papers (deadline October 31, 1997) is open to a broad range of submissions, with a particular emphasis on: stresses related to changes in health care systems; primary prevention of illness and impairment; needs of particular physician populations such as trainees, older physicians, minorities, women, and IMGs; physical illness and disability; rehabilitation, re-training, and re-entry; the relationship between physician factors and medical errors; physician and family self-care and reactions to illness or stress; reactions to bad outcomes and lawsuits; harassment of and by physicians; relationships among hospital programs, state programs and licensing authorities; and dealing with physicians who misprescribe.

For additional information on the conference or to obtain a paper submission form, call the AMA Department of Mental Health at 312-464-5066. Information can also be found on the World Wide Web at **www.ama-assn.org** or at **www-psy.bsd.uchicago.edu/~larry/uchome.htm**.

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Improvement Noted in Blood Pressure Management HCQIP Project

Significant improvement has been reported in a blood pressure management project which addressed the treatment of emergent blood pressure in stroke patients. The Health Care Quality Improvement Program project began as a spinoff from the Foundation's Stroke Management Project involving four hospitals. Analysis of the stroke project baseline data detected that 31.8 percent of the stroke patients sampled had emergent blood pressure treatment ordered. In 91.6 percent of these cases, the drug employed for the treatment was sublingual nifedipine.

A 1994 American Heart Association clinical guideline entitled "Management of Patients with Acute Ischemic Stroke" recommended that antihypertensive drugs be withheld unless the calculated mean blood pressure is greater than 130 mm Hg or the systolic blood pressure is greater than 220 mm Hg. When emergent blood pressure treatment is instituted, the best parenteral drugs appear to be those easily titrated and having a minimal effect on cerebral blood vessels, such as labetalol or Enalapril. Sublingual nifedipine (Procardia), it was noted, should be avoided because of rapid absorption and secondary precipitous decline in blood pressure.

A statewide random sample of acute care Prospective Payment System admissions in Mississippi having a principal diagnosis of stroke was taken to evaluate the treatment of emergent blood pressure. The results of the random sample showed that 23.85 percent of the stroke patients sampled had emergent blood pressure treatment ordered. In 80.77 percent of these cases, the drug employed was sublingual nifedipine.

In May 1995, this baseline data and the AHA guidelines were sent to all hospitals in Mississippi. Each hospital was asked to evaluate its care of patients with regard to the guideline. Hospitals were asked to collaborate, and if an opportunity for improvement was found, to submit an improvement plan.

Thirty-seven hospitals initially agreed to collaborate. A total of 31 hospitals submitted improvement plans in which they agreed to educate their staffs and monitor compliance with the AHA guideline.

Post-project monitoring to determine the effectiveness of the project began in January 1997. Records were requested from the collaborating hospitals to be sent to FMC for data abstraction. Records were received from 27 hospitals.

Aggregate data showed that 16.69 percent of the stroke patients sampled had emergent blood pressure treatment ordered. In 60.38 percent of these cases, the drug employed was sublingual nifedipine.

The hospital-specific data reflect significant improvement as well. Seven hospitals demonstrate a 0 percent order rate for emergent blood pressure treatment, and therefore a 0 percent usage rate for sublingual nifedipine.

Post-project monitoring indicates improvement in the treatment process of acute hypertension in acute stroke patients.

"Intense efforts are underway in the state to curtail the devastating effects of stroke by educating the public about the signs and symptoms of stroke and the importance of seeking early treatment," said Dr. James S. McIlwain, principal clinical coordinator. "It is encouraging to see the efforts at hospitals throughout the state in adhering to the latest guidelines for the treatment of stroke."

Pam Glass is the project manager. Further information about the Health Care Quality Improvement Project can be obtained by calling her at 601-948-8894.

The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the state of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this article does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of pattems of care, and therefore required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience with issues presented are welcomed.

Website Makes UMC Approachable in Cyberspace

An Ask the Doctor section is the latest way to access the University of Mississippi Medical Center's website which has been under construction for several months.

The site (at umcnews.com) also includes a searchable campus directory with phone and e-mail addresses and a faculty list.

Dr. Kenneth L. Moore, assistant professor of neurology and director of the head pain center at UMC, will answer e-mailed questions about medicine and health. Board certified in both internal medicine and neurology, he specializes in the diagnosis and treatment of difficult cases of head and face pain, but is prepared to answer questions on other topics as well.

No stranger to cyberspace, Dr. Moore also serves as the headache expert for CompuServe's Health Forums and for the American Medical Association's website for physicians. He is a consultant for MediConsult (mediconsult.com) which provides detailed medical reports about specific disorders and treatments.

Two website sections, Medical Center News and This Week at UMC, are frequently updated and now include photographs. The Medical Center News page was first used in November to provide updates on Governor Kirk Fordice's condition. UMC news releases can be found on that page several days before they are released to the news media.

A web version of the campus publication *This Week at UMC* can be accessed from UMC's main page. It includes the week's news events and the UMC cafeteria menu.

"We intend to keep these two sections and the Ask the Doctor section constantly updated, giving people on and off campus a reason to return to our page," said Jim Albritton, media coordinator in the Division of Public Affairs. "Nobody likes to visit a stale page. This one won't be."

Stories that appear on Medical Center News and This Week at UMC pages are archived and are keyword searchable. Questions and answers that appear on the Ask the Doctor page will also be archived and searchable.

Internet Solutions, Inc., the Jackson-based company that is working with the public affairs division in designing the UMC page, is currently assembling information and photos for the Health Care in Mississippi section which includes links to the University Hospitals and the Blair E. Batson Hospital.

New pages will also be designed for the Schools of Dentistry, Nursing, Health Related Professions and graduate programs.

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PHILLIPS, HUNTER, J., III, Bay St. Louis. Born New Orleans, LA, February 18, 1957; MD Tulane University School of Medicine, New Orleans, LA, 1983; dermatology residency, Charity Hospital, New Orleans, LA, 1983-86; elected by Coast Counties Medical Society.

RICE, WILLIAM L., Tupelo. Born Tupelo, MS, January 19, 1958; MD Vanderbilt University School of Medicine, Nashville, TN, 1984; orthopaedic residency, University of Wisconsin Hospitals & Clinics, Madison, WI, 1984-89; sports medicine fellowship, American Sports Medicine Institute, Birmingham, AL, 1989-90; elected by Northeast MS Medical Society.

SELBY, JOHN H., Greenville. Born Boston, MA, August 17, 1943; MD University of Texas Southwestern School of Medicine, Dallas, TX, 1969; surgery residency, Parkland Hospital, Dallas, TX, 1970-74; thoracic surgery residency, University Medical Center, Jackson, MS, 1975-77; elected by Delta Medical Society.

SHELTON, THOMAS B., Senatobia. Born Memphis, TN, April 3, 1954; MD University of Tennessee College of Medicine, Memphis, TN, 1981; surgery internship one year, University of Tennessee Center for Health Sciences, Memphis, TN; urology research, same 1983-84; urology residency, same, 1984-86; elected by Northeast MS Medical Society.

WARNICK, JAMIE S., Natchez. Born Decatur, IL, January 3, 1956; MD University of Illinois Medical School, Chicago, IL, 1982; pediatric residency, same, 1982-1985 elected by Homochitto Valley Medical Society.

WELSH, THOMAS E., Union. Born Chicago, IL, November 17, 1957; MD Medical College of Georgia, Augusta, GA, 1977; internal medicine residency, St. Mary's Health Center, St. Louis, MO, 1977-80; elected by East MS Medical Society.

WHITESIDE, PAUL L, Pontotoc. Born Jackson, TN, March 15, 1932; MD University of Mississippi School of Medicine, Jackson, MS, 1963; interned one year, Mobile General Hospital, Mobile, AL; elected by Northeast MS Medical Society.

ZOUBOUKOS, CONSTANTINE P., Jackson. Born Jackson, MS, November 19, 1964; MD University of Mississippi School of Medicine, Jackson, MS 1990; anesthesiology residency, same, 1992-95; elected by Central Medical Society.

Dates to Remember

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* * * * *

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Van Lemuel Lackey, M.D., (above) an internist and oncologist with Jackson Oncology Associates, has been selected as Governor for the Mississippi Chapter of the American College of Physicians (ACP). His term began during the Society's 78th Annual Session, held in Philadelphia, Penn. ACP is the nation's largest medical specialty organization, with membership composed of more than 100,000 internal medicine physicians and medical students. Dr. Lackey was elected to a four-year term by the organization, which has more than 600 members in its Mississippi Chapter. Assisted by local councils, his responsibilities will include scientific meeting planning, credentialing new members and disseminating College policy. He also represents ACP members on the National Board of Governors. Dr. Lackey is on the staff of Mississippi Baptist Medical Center and several other local hospitals.

Teri O. Dyess, M.D. has associated with Jackson Medical Clinic in the practice of Internal Medicine.

James C. Gilmore, M.D. has joined **Robert J. Derveloy, III, M.D.** in the practice of cardiovascular and thoracic surgery. A native of Oxford, Dr. Gilmore has been practicing in Memphis with the Cardiovascular Center, Inc. He received his medical degree from the University of Mississippi Medical Center. His internship and residency were completed at Mayo Graduate School in Rochester, Minnesota. A fellowship in thoracic surgery at Alton Ochsner Medical Foundation in New Orleans followed. He is certified by the American Board of Surgery and the American Board of Thoracic Surgery. Dr. Gilmore holds membership in the American College of Surgeons, as well as Southern Thoracic Surgical Association. Dr. Gilmore brings with him an expertise in heart and lung transplants and minimally invasive coronary bypass.

Kyle Ball, M.D., obstetrician-gynecologist, has had two articles he wrote published in *"Safari"* magazine with two more to be published in the coming year. The published articles relate successful hunting experiences.

John J. McGraw, M.D.; Cleveland E. Johnson, M.D.; Edward R.Turnbull, M.D.; David D. Madden, M.D.; Burt E. Bradford, M.D. and **George R. Bush, M.D.,** of Laurel, provided examinations for more than 500 athletes as part of an annual screening sponsored by South Central Regional Medical Center.

William Henry Barber, M.D., professor of surgery and surgical director of renal transplant at UMC, and **Benton M. Hilbun, M.D.,** a surgeon in Tupelo, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Dr. Barber and Dr. Hilbun are among a national network of over 2,000 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities. Established in 1922, the Commission on Cancer, which is composed of Fellows of the College and Liaison members representing more than 35 other cancer-related organizations, has approved more than 1,450 cancer programs in institutions across the country. The Commission reviews each institution's cancer program for conformity to their established standards, and encourages participating hospitals to equip and staff themselves so that they are able to provide the best in the diagnosis and treatment of cancer.

Terry Millette, M.D., a neurologist for Singing River Hospital in Pascagoula, was the guest speaker for the Jackson County Alzheimer's Disease and Related Disorders Support Group. Dr. Millette discussed Aricept®, the newest treatment available for Alzheimer's Disease

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

patients. Aricept® is used to help manage some of the major symptoms that may occur during the mild-to-moderate stages of Alzheimer's Disease. Dr. Millette also discussed other medications that are available for Alzheimer's patients.

Jim Williams, M.D., a pathologist for Forrest General Hospital's Laboratory Services, was the featured speaker for the inaugural meeting of Man-to-Man, a new group of men experiencing prostate cancer and other prostate conditions.

Edsel F. Stewart, M.D. announces his retirement from the practice of Gynecology.

Edward Rigdon, M.D., associate professor of surgery and director of the general surgery division at the University Medical Center (UMC), has been named 1997 Young Surgeon by the Mississippi Chapter of the American College of Surgeons (ACS). He received an expense-paid trip to Chicago for the annual meeting of the Young Surgeons of the ACS.

Diane K. Beebe, M.D., associate professor of family medicine and vice chair of the department at UMC, has been reappointed as a member of the ACGME National Residency Review Committee for family practice. This committee is one of the 26 specialty RRCs that accredit US residency programs.

The University of Mississippi Medical Center hospital medical staff has elected new officers. **Joe Files, M.D.,** professor of medicine and interim chair of the department, has been named chief-of-staff. **Stan Chapman, M.D.,** professor of medicine and director of infectious diseases is vice chief-of-staff, and **Gilliam Hicks, M.D.,** associate professor of medicine, is secretary.

Samuel B. Johnson, M.D., professor and chairman of ophthalmology, was in Daytona Beach, Florida for a site visit at the Florida Rehabilitation Center for the Blind.

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I. K. Ho, M.D., professor of medicine and pharmacology at UMC, was in Oxford to present at a meeting of the University of Mississippi pharmacology department.

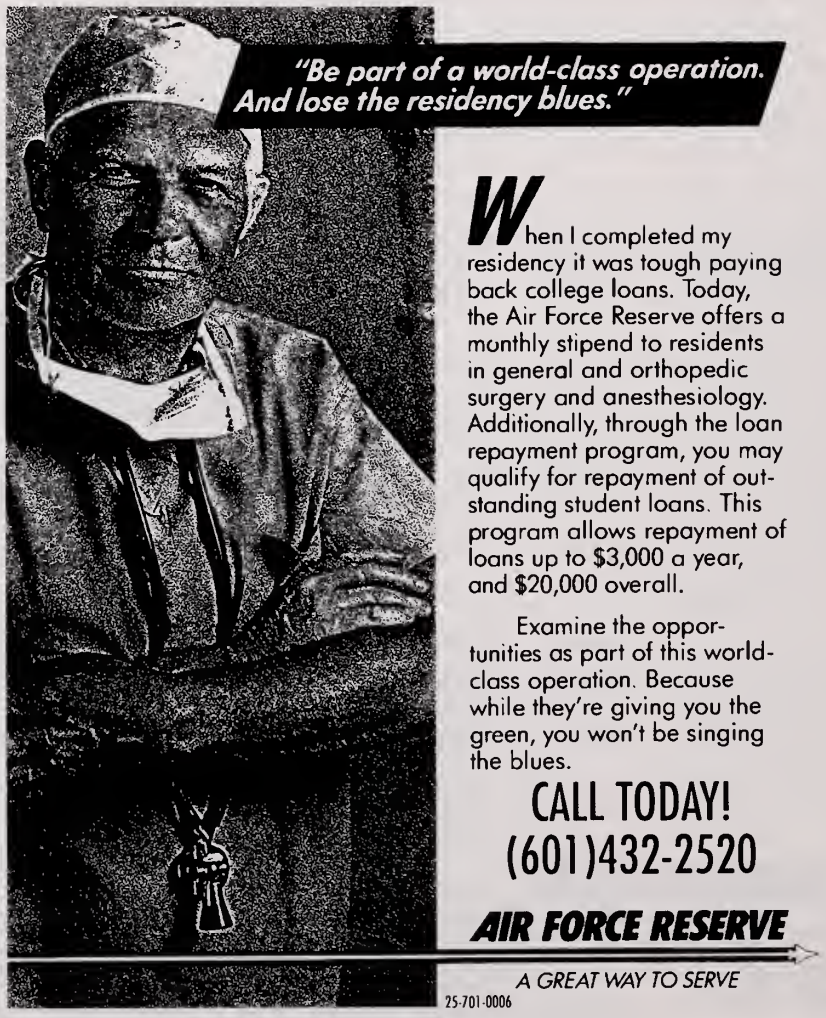
Donald A. McClain, M.D., professor of medicine and director of the endocrinology division at UMC, presented at the Southern Society for Clinical Investigation at a meeting in New Orleans.

Steven Bigler, M.D., assistant professor of pathology at UMC, gave a presentation at the United States and Canadian Academy of Pathology meeting in Orlando.

Ramesh Patel, M.D., professor of radiology, received the Alpha Omega Alpha Professor of the Year Award for outstanding teaching ability. The UMC chapter of AOA gave Dr. Patel the award at the annual induction ceremony. Senior medical student Raymond Orgler, who nominated Dr. Patel for the award, said Dr. Patel went "above and beyond what he had to do when we rotated through radiology. He took an extra hour out of his week to meet with us, an hour he wasn't required to give. He is just a very good teacher."

John H. Eichhorn, M.D., anesthesiology chairman at UMC, was visiting professor at New York University's Department of Anesthesiology where he spoke on "Safety Monitoring in Anesthesia." He also spoke on "Risk Management in Anesthesia" and "The Future of Anesthesia Safety" at the 47th annual Postgraduate Symposium on Anesthesiology in Kansas City, Missouri.

Suresh Chintamaneni, M.D. announces the closing of his surgical practice in Lucedale.



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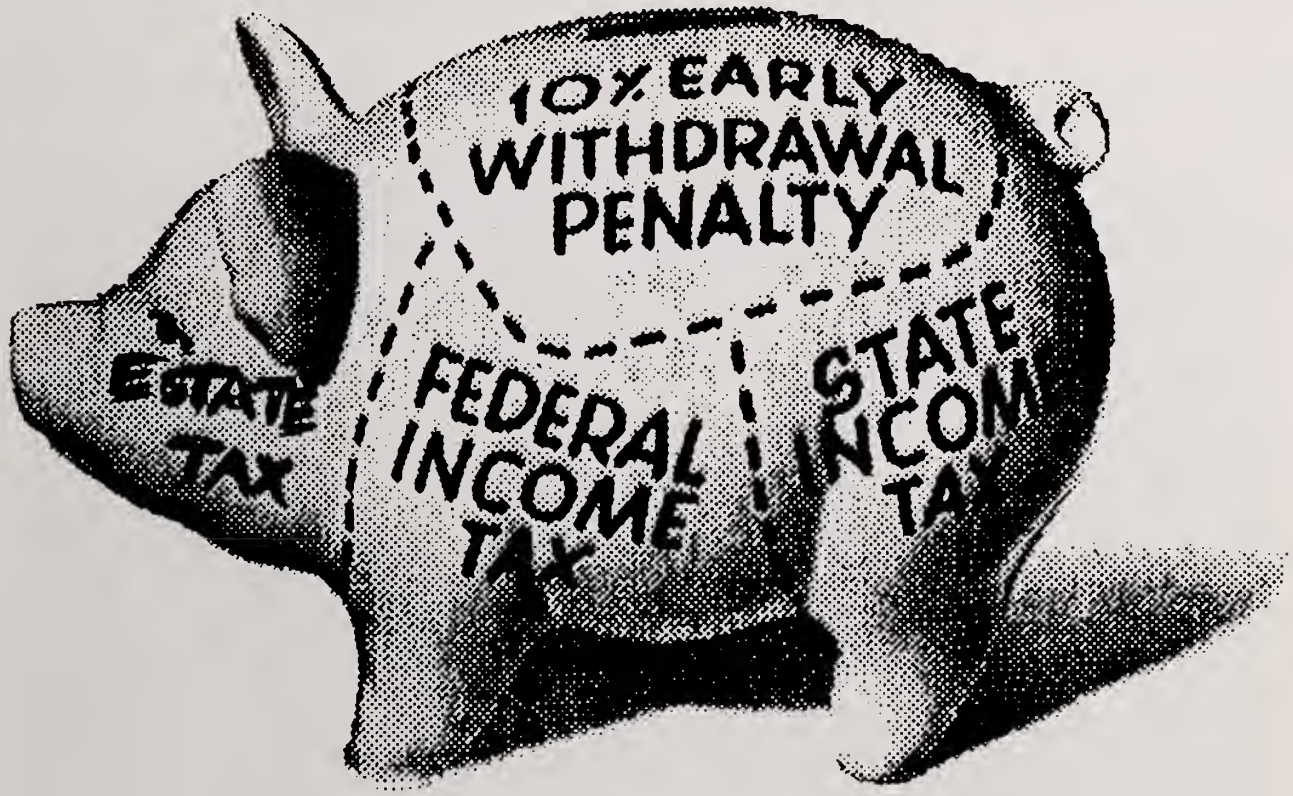
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SCIENTIFIC ARTICLES

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Clinicopathologic Case XVIII

SPECIAL ARTICLE

There is a Doctor in the House and Here's What He Wants You to Know

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Treatment of Spontaneous Pneumothorax in a Rural Hospital Setting

David James Congdon, BA
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Introduction

Pneumothorax occurs when air is introduced into the space between the parietal and visceral pleura. Pneumothorax can be either the traumatic or spontaneous variety. Of the spontaneous variety there are two types: primary and secondary. Primary spontaneous pneumothorax occurs with no underlying lung disease while secondary spontaneous pneumothorax occurs due to some underlying lung pathology. The yearly incidence of spontaneous pneumothorax is 8.6/100,000.[17] The typical patient that presents with a spontaneous pneumothorax is a male age 20-40 years without clinically significant lung disease. An underlying lung pathology is found in fewer than 20% of these patients.[1-4] This holds true in the usual 20-40 year old age group although in the patient who is under 16 years of age up to 42% have some definable underlying lung pathology.[1] Spontaneous pneumothorax in the young child has particular significance if he/she has cystic fibrosis. In one series the average survival after spontaneous pneumothorax in the young cystic fibrosis patient was less than a month.[1] The chance of finding some underlying lung pathology also increases if the patient is greater than 40 years of age.

Treatment of spontaneous pneumothorax may require hospitalization and therefore can be relatively expensive to both patient and hospital. We looked at the treatment of spontaneous pneumothorax in a rural hospital in order to see if the treatment outcomes and patient characteristics differed from the literature.

Methods:

We reviewed the records at Field Memorial Community Hospital over a period spanning 1987-1997. During this time period eleven patients were treated for spontaneous pneumothorax. These patients were treated with either tube thoracotomy or observation. Two patients out of the eleven were being treated for a recurrent episode of pneumothorax while the rest were seen with their first episode of spontaneous pneumothorax.

Results:

Eleven patients were admitted between 1987 and 1997 for treatment of both primary and secondary spontaneous pneumothorax. Two of eleven patients (18%) had secondary spontaneous pneumothorax while nine of eleven (82%) had a primary spontaneous pneumothorax. The overall average age was 50 years old. The average age for primary and secondary spontaneous pneumothorax was 45 and 75 years old respectively. The two patients with secondary spontaneous pneumothorax had emphysema and small cell cancer of the lung. Seventy-three percent of the patients were male. Sixty-four percent of pneumothoraces were on the right side and only 18% of pneumothoraces involved less than 20% of the effected

side. Eighteen percent of patients had accompanying lung disease.

Table 1

Patient Characteristics

	FMCH	LITERATURE
Age in Years		
-Average Age for All	50 yrs	
-Primary SP	45 yrs	20-40 yrs
-Secondary SP	75 yrs	>40 yrs
Recurrent Episode	18%	
Initial Episode	82%	
Percent Male	73%	65-70%
Types of S. Pneumo		
-Primary	82%	
-Secondary	18%	< 20%
- <60 Years	0%	
- >60 Years	50%	
Percent on Right	64%	50%
Blebs on CXR	18%	15%
Percent < 20%	18%	

No patient less than 60 years of age had accompanying lung disease compared to 50% of those greater than 60 years of age. Eighteen percent of patients' x-rays showed blebs or bulla. Ninety-one percent were treated with tube thoracotomy and 9% were treated by observation.

There was an overall treatment failure rate of 18% but of the patients treated with tube thoracotomy the failure rate was 20%. Eighteen percent of patients were treated for a recurrence while 82% were treated for a first episode. The average hospital days required for treatment were 7.1, this included one patient treated by observation (one hospital day). Of the patients treated with tube thoracotomy the average hospital days were 7.7 days. The hospital days required for treatment were dependent upon the age of the patient. The average stay for patients, treated by tube thoracotomy, less than 60 yo was 4.7 days while that greater than 60 yo was 12.3 days. Even in patients greater than 60 years old with primary spontaneous pneumothorax, with no underlying lung disease, the average hospital stay was 10.5 days.

Table 2

Treatment Data and Outcomes

	FMCH	LITERATURE
Treatment		
-Observation	9%	
-Tube Thoro	91%	Most common TX
Treatment Failure		
-Observation	0%	
-Tube Thoro	20%	20-35%
Hospital Days		
-Avg of all Tx	7.1 days	
-Thoracotomy	7.7 days	
- <60 years	4.7 days	3.9 days
- >60 years	12.3 days	
-No Lung Disease	10.3 days	

Discussion:

The most common etiology of spontaneous pneumothorax is rupture of a lung bleb or bulla. The two next most common causes are destructive parenchymal disease and proximal airway obstruction.[2] We had only one patient with an identifiable underlying cause for his spontaneous pneumothorax. This particular patient had emphysema. A number of diseases, other than emphysema,, are associated with spontaneous pneumothorax including: tuberculosis, AIDS, cystic fibrosis, and certain genetic diseases. It was once thought that spontaneous pneumothorax only occurred in association with tuberculosis. We now know this not to be true although an association with spontaneous pneumothorax and tuberculosis remains.[6] Spontaneous pneumothorax is seen in a variety of genetic diseases such as cystic fibrosis[7,8] and Marfan's syndrome.[9] There is also a familiar form of spontaneous pneumothorax linked to autosomal dominant gene with incomplete penetrance and a male predominance.[10] There has been an increase in AIDS related spontaneous pneumothorax over the past few years.[5] There is also a rare form of spontaneous pneumothorax in which a pneumothorax develops predictably within a few days of each menses. This type of spontaneous pneumothorax is called a Catamenial Pneumothorax, affects women less than thirty years of age, and has a predominance for the right side. The exact cause is unknown but pleural endometriosis has been proposed as a possible mechanisms.[Text]

The diagnosis of pneumothorax is arrived at by history, physical exam, and chest x-ray. The most common initial symptoms are chest pain (100%), dyspnea (41%), and cough (6%).[1] We saw a similar trend in our patients' symptoms although we did not have anyone with a sole complaint of cough. The diagnosis of spontaneous pneumothorax can be difficult based on clinical findings alone. To detect a decrease in breath sounds a pneumothorax must be greater than 25%. A young adult with no deriving lung disease can be asymptomatic with a normal blood gas and a near complete collapse of the lung. If a patient has underlying lung disease, with formation of pleural space adhesions, they can develop a pneumomediastinum or subcutaneous emphysema associated with their pneumothorax.

Radiographic evidence includes absence of lung

markings and often a small amount of pleural fluid which is usually insignificant. Patients may occasionally get a hemothorax which requires exploration but this is rarely seen with spontaneous pneumothorax. Lung blebs or bullae are the most common cause of spontaneous pneumothorax but are only rarely seen on radiographs. We saw lung blebs in only 18% of our patients on chest x-ray which was similar to the 15% reported in the literature. Eighty-five percent of these blebs and bullae are found in the lung apices.

We had only one connection in our experience with treatment of spontaneous pneumothorax and that was a transient episode of pulmonary edema. Spontaneous pneumothorax is usually not immediately life threatening but can be if a tension pneumothorax develops. In this case needle aspiration of the pneumothorax can be life-saving. Other complications encountered in the treatment of pneumothorax include pulmonary edema, bleeding and infection. Rapid expansion of a pneumothorax can lead to the development of pulmonary edema (21 of 146 cases/ Matsuura). Patients at the greatest risk were those 20-39 years old with a large pneumothorax. The mortality rate with the development of pulmonary edema can be as high as 20% in this group of patients. Recurrence rates of primary and secondary spontaneous pneumothoraces are similar. The recurrence rate depends more upon the type of treatment than on whether it was a primary or secondary spontaneous pneumothorax.

There are a number of treatment options available for spontaneous pneumothoraces. They include observation, tube thoracotomy, chemical and mechanical pleurodesis, and operative procedures. Regardless of the treatment modality, the treatment of pneumothoraces is followed by serial chest x-rays and physical exam. The simplest treatment of spontaneous pneumothorax is observation. A pneumothorax can, in general, be observed if less than 20% of the lung is involved, the patient is mildly symptomatic and the pneumothorax has not increased in size over 6-8 hours. The pneumothorax will be slowly absorbed by the pleural surfaces over several days. Needle aspiration has decreased the time needed for spontaneous resolution but is not necessary for successful treatment.

Tube thoracotormy is the most common invasive procedure with a success rate of between 65-80%.[1] Instillation of intrapleural tetracycline reduces the rates of recurrence from 41% to 25%.[13] Pleurodesis can be done through the drainage tube. Adequate analgesia is a must as this procedure can be extremely painful. No anesthesia is necessary if the patient is properly premedicated. Other compounds that have been used for recurrence rates are no better at four percent.[22] Operative therapy provides significantly lower recurrence rates but does have greater morbidity and cost for the patient.

Overall, our treatment of spontaneous pneumothorax compared very favorably with the literature. We used only two treatments, tube thoracotomy and observation. Our failure rate for tube thoracotomy was very good at 20% which was at the lower end of the range seen in the literature. The one variable was the length of stay for invasive treatment of spontaneous pneumothorax. The average hospital stay for treatment of spontaneous pneumothorax in the literature is around four days. Our patients stayed an average of 7.7 days for treatment by tube thoracotomy. Another trend we noticed was that the length of stay increased significantly for patients greater than 60 years of age. Patients over sixty years of age stayed 7.6 days longer than younger patients. In one study comparing the cost of tube thoracotomy to treatment by thoracic vent, the thoracic vent was found to be much less expensive. The average cost for treatment of tube thoracotomy was $6,160 compared to $500 for that of thoracic vent. Decreasing the length of stay can significantly decrease the cost of treating pneumothorax. This difference in cost would be even more significant for Field Memorial since patients remain in house for longer periods of time on average.

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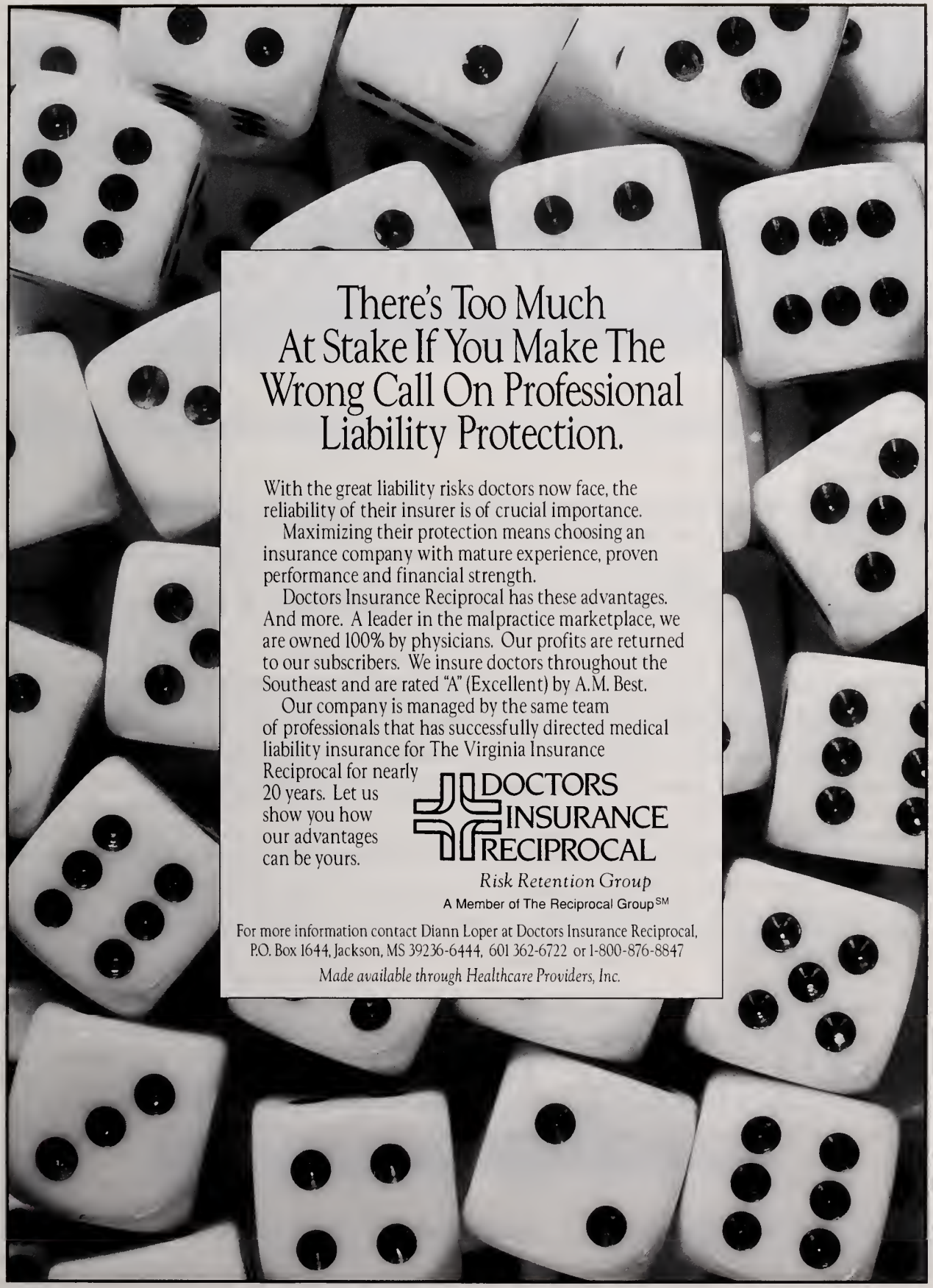


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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XVIII

Selection and Preparation:
Edward F. Daly, III, M.D.
Nancy T. Kubiak, M.D.

Joe C. Files, M.D., *Editor*

Differential Diagnosis: Robert McMurray, M.D.
Pathological Findings: Nancy Kubiak, M.D.

CASE PRESENTATION

The patient is a 69 year old white gentleman who began having numbness and dysesthesia in his toes in January of 1994, that progressed to involve his feet, then his knees. By May of that same year, he had noticed numbness and hypesthesias in his hands, wrists, and torso. He was evaluated by Neurology and was thought to have an idiopathic sensorineural polyneuropathy. After discharge, the patient noticed a rash had developed on his chest and trunk. In early June, he had some fevers that were treated with oral antibiotics, but no definite source was found. He was also found to be anemic and was given two units of packed red cells. His fevers resolved. In July, he noticed non-painful subcutaneous nodules that would come and go over his extremities. Later that month, he became hoarse. He was admitted to the VA in August complaining of arthralgias, lower extremity edema, dry cough, fatigue, and myalgias. He denied fever, neck stiffness, photosensitivity, new medications or chemical exposures, abdominal pain, adenopathy, hematuria, visual changes, mouth sores, hemoptysis, PND, orthopnea, or melena. He denied a history of syphilis or hepatitis B, and said that he had been able to donate blood early in the year.

His past medical history is significant for a well differentiated diffuse lymphocytic lymphoma treated in 1989 with a tonsillectomy and chemotherapy for four months and was thought to be in clinical remission. He had prostate cancer diagnosed in April, 1994, that was limited to the prostate. His nodes were all negative for cancer. He also had a history of hypertension.

He had no known drug allergies and his family history was significant only for cerebral vascular disease. His medications on admission to the VA included Elavil 50mg q.h.s., Maxzide 25mg every other day, Metamucil prn., iron sulfate 325mg t.i.d., ibuprofen 600mg t.i.d. prn, and Colace prn.

His physical exam showed a blood pressure of 111/58, a pulse of 101, respiratory rate of 22, and a temperature of 97°. HEENT: unremarkable fundi or pharynx. Cardiovascular examination revealed a normal S1 and S2. There were no murmurs, rubs, or gallops. Lungs were clear to auscultation and percussion bilaterally. Abdomen was soft, non-tender with normal bowel sounds. There was no hepatosplenomegaly. Extremities revealed pitting edema to the right leg distal to the ankle, but no cyanosis or clubbing. Motor strength was 4-5 throughout and loss and sensation with dysesthesia to normal touch. Reflexes were absent at the ankles bilaterally but were normal elsewhere. There was no adenopathy noted. He did have a petechial rash on his hands and lower extremities.

Laboratory data include a hemoglobin of 8.3, a platelet count of 367,000, his MCV was 77, and RDW was 33. His white count was 29,000, his serum iron 32, ferritin 313, and total iron binding capacity was 237. His sodium was 131, potassium 3.8, chloride 106, CO2 18, BUN 77, creatinine 3, glucose 106, and a calcium of 9.2. His erythrocyte sedimentation rate (ESR) rate was > 120. Liver enzymes were within normal limits. His hepatitis B surface antigen was negative as well as his hepatitis C virus antibody. RPR was negative. ANA was negative. C3 and C4 levels were normal and antineutrophil cytoplasmic antibody (ANCA) was < 1:10. Cryoglobulins were negative. Serum protein electrophoresis showed a nonspecific inflammatory pattern. Urinalysis had a specific gravity of 1.020, a pH of 5, trace blood, and 250 white cells. The urine culture was positive for E coli.

For Dr. McMurray, our question is what is your differential diagnosis and how would you approach this clinical problem.

Dr. McMurray: The primary problems in the case were 1) a neurologic problem, and 2) a dermatologic problem.

The dermatologic slides with the case appeared to be a lower extremity with postinflammatory hyperpigmented macular lesions. By history, it was a petechial or purpuric rash, so that would suggest that it was perhaps palpable purpura at one point. A lower extremity with hyperpigmented purpura or nodules suggests to me, as a rheumatologist, hypersensitivity vasculitis, polyarteritis nodosa, or cryoglobulinemia. We were told that the

cryoglobulins were negative. The picture of the hands had multiple petechial hemorrhages. I would also note that there is some desquamation. Desquamation may occur in number of different diseases, perhaps following high grade fever. In children, one thinks of Kawasaki's disease with fever, vasculitic lesions, and desquamation. In this case, the desquamation most likely represents eczematous eruptions or, perhaps, an id reaction from a dermatophytosis. The major point here is a petechial rash of the hand. A rheumatologist thinks vasculitis right away, but other diagnoses that should come to mind would be a rickettsial infection (Rocky Mountain spotted fever), syphilis, or embolization.

In this patient there are multiple organ systems involved. The nervous system is involved in that he has a stocking glove sensorineural polyneuropathy that the Neurology service called idiopathic sensorineural polyneuropathy. The skin is involved with rash and we have this history of subcutaneous nodules. The renal system is involved based on an elevated creatinine, an active urine sediment, and a urinalysis with trace blood. I wasn't given how many red blood cells per high powered field there were, so I am going to assume there are less than five with just trace blood. There were 250 white blood cells in the urine and the culture was positive for E coli. I was not given whether any protein was present. The musculoskeletal system was involved. There were arthralgias, myalgias, and the patient was weak. The hematopoietic system was involved with a marked leukocytosis, and an anemia that would qualify as an anemia of chronic disease. The patient had constitutional symptoms, such as fever and fatigue. There were several complicating factors, at least from a rheumatologic perspective, in this history. He had a history of lymphocytic lymphoma so a recurrence in association with vasculitis is possible. He also had a history of hypertension. His medications are concerning particularly given his renal involvement. He was on Ibuprofen, as well as a diuretic combination for his hypertension.

Regarding his diagnostic workup, a ferritin being elevated in this case is of no help. It's an acute phase reactive so it is expected to be elevated. Likewise, I don't usually order a sedimentation rate; ordering it only when I am considering the diagnosis of temporal arteritis or polymyalgia rheumatica. As you would expect, in a patient with a systemic disease, the ESR is markedly elevated. A hepatitis panel was ordered. That would have been a very good diagnosis to make because hepatitis C virus is emerging as a common cause of cryoglobulinemia. But, cryoglobulins were negative. C3 and C4 complement levels were normal. Occasionally, depressed complement levels help in the diagnosis of a vasculitis.

In considering systemic diseases, I like to think of the word "vindicate" (Table 1). I like the word vindicate because, as a mnemonic, the word vasculitis is at the top, and we often don't think of vasculitis as a cause of systemic disease. When evaluating the patient who has a systemic disease, one should have covered major systemic disease categories: **V**asculitis, **I**nfection, **N**eoplasia, **D**rugs, **I**mmunologic disorders, **C**onnective tissue diseases, **A**llergic responses, **T**oxins, and **E**ndocrine diseases. I would not propose in my differential all of these things, but for the discussion, let's consider vasculitis first. There are a number of different vasculitides, and one should entertain the diagnosis when you have more than one or two organ systems involved. Briefly, **V**asculitis may be classified on the size of the vessels involved. Hypersensitivity/leukocytoclastic vasculitis is a small vessel vasculitis; polyarteritis nodosa is a medium vessel vasculitis; giant cell arteritis/temporal arteritis and Takayasu's arteritis are large vessel vasculitides. Wegener's granulomatosis and allergic granulomatosis involve small and medium vessels.

TABLE 1
DIFFERENTIAL DIAGNOSIS MNEMONIC FOR SYSTEMIC ILLNESSES

Vasculitis
Infection
Neoplasia
Drug Reaction
Immune Disorder
Connective Tissue Disease
Allergy
Toxins and Poisons
Endocrine Diseases

Of course, a major diagnosis to rule out in this patient is **I**nfections. Basically, we have ruled out viral infection with negative hepatitis B and hepatitis C. Other infections could be present, such as subacute bacterial endocarditis. We weren't given that this patient had any blood cultures drawn or an echocardiogram to rule out a bacterial endocarditis. We will keep that in mind.

Next is **N**eoplasia. Many of the manifestations of paraneoplastic syndromes can present with a vasculitic rash and he has a prior history of lymphoma. Infection and neoplasia are really the bugaboos of a rheumatologist in a patient who has a systemic illness. **D**rugs are also a consideration in this patient. He is on a diuretic which

could have caused a hypersensitivity reaction leading to a vasculitic purpuric skin rash. Immune disorders: We have already mentioned cryoglobulinemia a couple of times. The cryoglobulins were negative, but one has to be suspicious of negative results in the appropriate clinical setting. By definition, cryoglobulins precipitate when it's cold, so if the blood was drawn but wasn't kept at 37° before it was transported to the lab, the cryoglobulins could have precipitated. If drawn incorrectly, there will be a false negative. Given the skin rash, his neuropathy, etc., we want to consider cryoglobulinemia. Anti-phospholipid antibodies should also be considered as a possible Immunologic diagnosis in this case.

The next consideration is Connective tissue disease. We did have synovitis. We don't have a history of any photosensitive skin rash. We just have nonspecific arthralgias and myalgias. There is no suggestion of SLE, RA, Scleroderma, or polymyositis.

Other diagnoses in the differential, using the mnemonic "vindicate", include Allergy, Toxins, or Endocrine disorders. Given the current available data, this patient has vasculitis, an infection, or malignancy. I would order additional invasive tests or biopsies.

Given his multisystem disorder and the relatively chronic nature of it, I decided to focus on vasculitis. The vasculitides are characterized by inflammation in the blood vessel wall that results in damage to blood flow. The involvement may include only one organ system such as the skin or many organ systems in vessels of one or many types. The clinical syndromes are result of the ischemia to the tissue caused by the inflammation in the blood vessels.

Once I have ruled out infection or malignancy in this patient, the problem is to decide which type of vasculitis he may have and how it should be treated. His problems have gone on too long so we'll throw out drugs and viral infections as causes of hypersensitivity vasculitis. Hepatitis B and C antigens were negative. The ANA was negative and the rheumatoid factor wasn't reported. Therefore, we will discount RA, SLE, and hepatitis associated vasculitis. The reason to exclude hepatitis is that between 5-15% of polyarteritis nodosa patients will have a positive hepatitis B surface antigen. That's the reason to get hepatitis antigens and antibodies. We really don't have any pulmonary involvement except for a dry hacking cough, so it doesn't appear that it would be Wegener's granulomatosis although we do have renal involvement. There could be microscopic polyarteritis or glomerulonephritis associated with a positive anti-neutrophil cytoplasmic antibody (ANCA). The protein wasn't given, so I am going to assume that it was negative. If a patient had renal failure on the basis of vasculitis, I would expect them to have an active urine sediment with protein and a number of red blood cells. In this case, the kidney disease, at least the urine sediment, is due to infection and not due to a glomerulonephritis.

To continue the workup, we must consider biopsy, angiogram, and echocardiography to arrive at a diagnosis of polyarteritis nodosa or some "mimickers". Mimickers of vasculitis are given below (Table 2). If we have to biopsy this patient, where are we going to go? What organs are good biopsy sites? The kidney is a good biopsy site if it's involved. The sural nerve is a good biopsy site if there is a neuropathy. The rectal mucosa is a good blind biopsy site, as is the testes. Skin biopsy may confirm involvement, but other organ involvement must be excluded. In Wegener's granulomatosis, the kidney and nasopharynx are popular biopsy sites. One test that we frequently overlook is angiography. One test that isn't frequently performed, particularly if the patient refuses a kidney biopsy or an internal organ biopsy or if they have bowel involvement, is an arteriogram. When considering a vasculitis of an isolated extremity or certainly of the bowel, an angiogram would be an appropriate test.

TABLE 2
CONDITIONS MIMICKING VASCULITIS

Subacute Bacterial Endocarditis
Cholesterol Embolization
Cardiac Embolization
Atrial Myxoma
Left-sided Thrombus
Thromboangiitis Obliterans
Antiphospholipid Antibody Syndrome
Thrombotic Thrombocytopenic Purpura
Rickettsial Infections
Ergotism

When you biopsy the skin, you should ask the dermatologist, if you are considering vasculitis, to do an incisional biopsy. If you don't biopsy deep enough, the dermatologist would be lucky to get a medium sized artery. They are most likely to see capillaries and will read it out as a leukocytoclastic vasculitis. Then, you still have the question, "Do I treat with aggressive immunosuppression, or do I watch the patient and hope their skin disease resolves?" The point is that when you have a cutaneous vasculitis, you should rule in or rule out systemic involvement. If it is a vasculitis isolated to the skin, you may want to withdraw the causative agent, or observe the patient for a period of time.

What type of vasculitis does this patient have? He has more than a leukocytoclastic or hypersensitivity vasculitis, based on his multiple organ involvement. His presentation is not that of a temporal arteritis or a Takayasu's. His demographics, being a middle aged man, and symptoms/signs suggest polyarteritis nodosa. Polyarteritis nodosa is a small to medium sized artery inflammation that involves the skin, kidney, peripheral nerves, muscle, and it can involve the gut. Involvement of the other organs are rare. The most common organ involvement is a peripheral nerve with mononeuritis multiplex. A problem with this case is that this patient did not have mononeuritis multiplex. He had a symmetric sensory neural polyneuropathy. That can occur in polyarteritis, but not as commonly as mononeuritis multiplex.

In 1990, the American College of Rheumatology published diagnostic criteria for all vasculitides. The criteria for the classification of polyarteritis nodosa (PAN) include weight loss, livedo reticularis (which is a reticular pattern over the skin as opposed to petechial rash), myalgias, weakness, and polyneuropathy. He had an elevated BUN or creatinine, but he did not have hepatitis B, which also are diagnostic criteria for PAN. He did not have an arteriographic abnormality, and I was told that on a biopsy, he had a leukocytoclastic vasculitis. If you have three of these 10 criteria, there is an 80% specificity for polyarteritis. I think that this patient probably had polyarteritis nodosa.

A recurrent theme is that it is not good for a rheumatologist to misdiagnose an infection or a malignancy as a rheumatologic condition, and subsequently treat with high dose corticosteroids or immunosuppressives. Therefore, always evaluate vasculitic patients for an infection or malignancy. Also consider "mimickers" of vasculitis (Table 2): atrial myxoma, bacterial endocarditis, and cholesterol embolization syndrome which can occur in the upper extremities, but is frequently seen following an angiographic procedure from the upper or the lower extremities.

What would I have done initially in this patient? I would have evaluated the other causes of his renal failure. He did have a urinary tract infection, but that doesn't explain his elevated creatinine. I would have obtained an ultrasound to make sure that he did not have an obstructive uropathy or renal insufficiency with small kidneys from long-standing hypertension. I would have stopped his Ibuprofen if he was taking it, since Ibuprofen can precipitate renal insufficiency. I would have obtained blood cultures to rule out SBE. I would have obtained an echocardiogram and treated his urinary tract infection. With a 29,000 white blood cell count, I would make sure that he hasn't developed a recurrence of his lymphoma or a second hematologic malignancy. I would obtain an incisional biopsy of the skin or peripheral nerve.

If I were confident with the diagnosis of polyarteritis, and infection and malignancy were excluded, then I would start him on Prednisone, 1mg/kg/day, in a divided dose and leave him on that for at least two weeks and monitor his clinical response. I would consolidate to a single daily dosage of 60mg/day for two weeks and continue that dosage for at least two months total if his signs and symptoms had resolved completely. If he had resolved only partially, I would probably continue it longer. After two months if he were improving, I would begin a 15% dose taper every 2-4 weeks until I reach a dose of 20mg. After that, I would slow the taper to about 10% or about 2 1/2mg every 2-4 week, and then finally taper off. Of course, add a cytotoxic drug at any point in this corticosteroid therapy if you were confident in the diagnosis and he had progressive disease. When would you start out with a cytotoxic, like cyclophosphamide or azathioprine? When there is a rapidly progressive vasculitis with visceral involvement.

***Dr. Kubiak*:** The patient did undergo several biopsies; unfortunately those slides have been lost and are no longer able to be seen. I do have the report. He did have a skin biopsy, not incisional but punch biopsy that did show leukocytoclastic vasculitis. His kidney biopsy was suggestive of hypertensive changes with glomerular sclerosis, but not any other finding. Because these were negative, he was sent to sural nerve biopsy. That report showed patchy axonal dropout and some vasculopathy consistent with ischemia. The example they quoted would be diabetic. It was congo negative, Trichrome negative, and H&E had no revealing findings.

It was thought clinically that the patient either had one of the vasculitic syndromes or recurrence of his lymphoma. He was begun on Prednisone with a change in his creatinine down to 1.5. He received steroids: Prednisone 40mg/day. He improved on that regimen and went home. When seen back in clinic, he had not completely resolved all his symptoms. At that point, I believe Cytoxan was added to his regimen. Shortly after that, he was admitted with a neutropenic fever. This was the cause of his demise.

Diagnosis: Leukocytoclastic vasculitis, probable polyarteritis nodosa, clinically indolent lymphoma, but never firmly established.

TABLE 3
DIAGNOSTIC CRITERIA FOR DIAGNOSIS OF POLYARTERITIS NODOSA (THE PRESENCE OF 3 OR MORE HAS A SENSITIVITY AND SPECIFICITY OF > 80%)

> 4 Kg Weight Loss
Livedo Reticularis
Testicular Pain/Tenderness
Myalgias/Weakness
Mononeuropathy or Polyneuropathy
Diastolic Blood Pressure > 90mm Hg
Elevated BUN or Creatinine
Hepatitis B Virus
Arteriographic Abnormality
Biopsy of Artery Showing PMN Infiltration

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***Dr. Files** is Professor of Medicine and Interim Chairman for the Department of Medicine;*
***Dr. McMurray** is Assistant Professor of Medicine.*
***Dr. Kubiak** and **Dr. Daly** were Chief Medicine Residents in the Department of Medicine at the University of Mississippi Medical Center, 1995-1996.*

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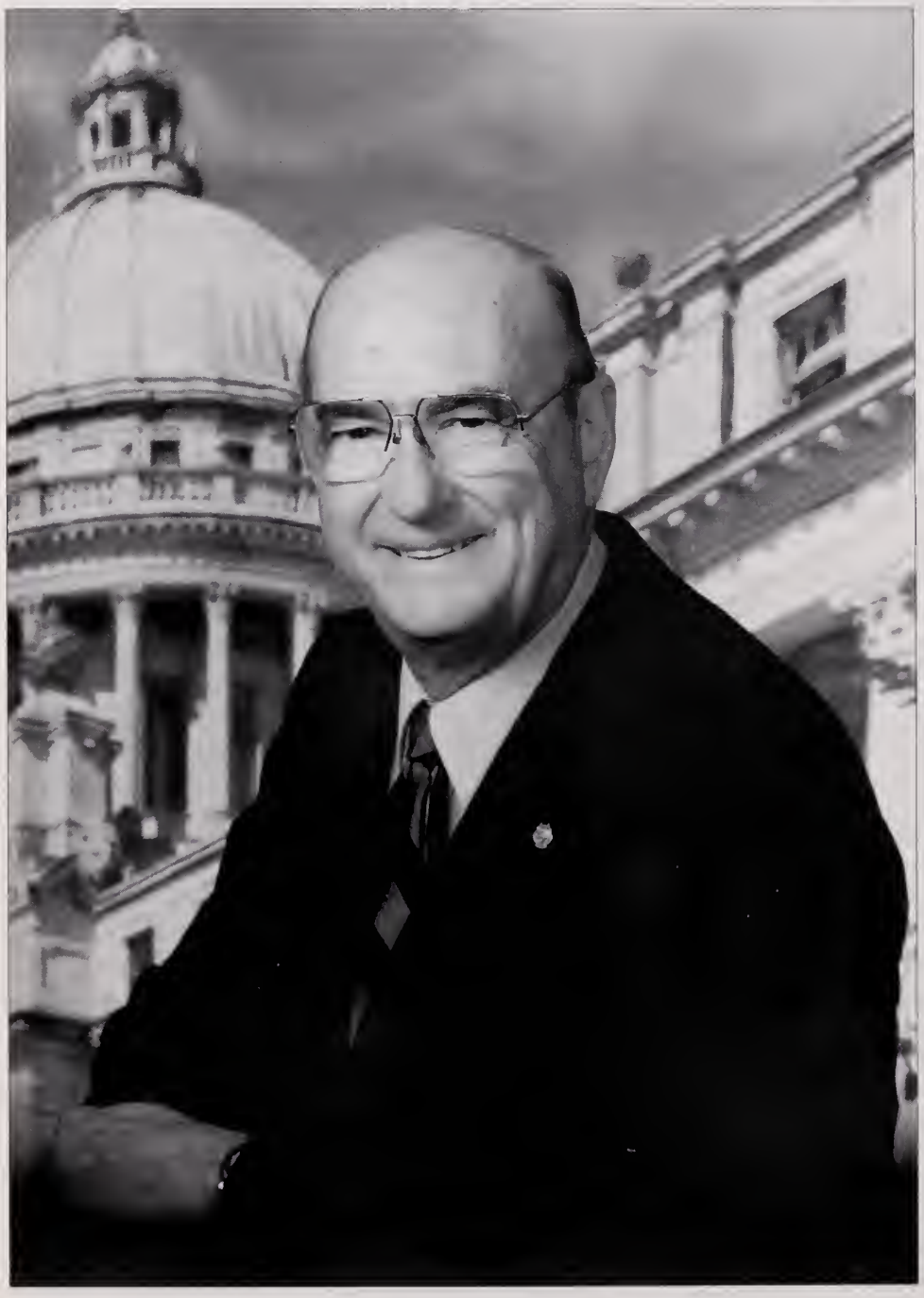
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There is a Doctor in the House And Here's What He Wants You To Know

Karen A. Evers



Who is Representative Doctor Jim C. Barnett? Those in the Mississippi Legislature know him as "the only doctor in the House." Dr. Barnett has represented Brookhaven's District 92 for the last six years. With a specialty in family practice and general surgery, he had served Brookhaven as a physician for 36 years. "There couldn't be a better place to practice medicine than Brookhaven," Barnett said.

During his 36 years, Barnett served as chief of staff at King's Daughters Hospital and two terms as president of the South Central Medical Society. He was a member of the State Board of Mental Health for over 13 years, serving twice as chairman of the board. He has also been a clinical instructor at the University Medical Center in Jackson.

Barnett has served on the MSMA Council on Legislation and also as president of the Southern Medical Association in 1990.

So why did he decide to run for office in the State Legislature? As president of the Southern Medical Association, veteran physician Barnett had the opportunity to visit 16 states. "All of those

states had a physician in the Legislature with the exception of Arkansas and Mississippi and I just decided one day that I would become a candidate. Obviously, my wife said I had rocks in my head, but anyway I did run."

Barnett, was elected in 1991. He's been reelected twice, in 1992 and in 1995 without opposition after legislative redistricting. "It's been fun ever since," said the representative who recently made his way through his sixth session. "I was approaching retirement age so it was maybe easier for me to run than someone younger just out of training and starting a practice," he said.

His wife, Roberta, who was president of the Southern Medical Association Alliance while her husband was president, views her husband's political career as an extension of his medical profession. "Legislative problems are essentially the same. He's still helping people," Roberta said. "He really enjoys it, and I think he's doing a good job."

Barnett, who is currently chairman of the Southern Medical Association Board of Trustees, said he sees differences in the two professions, but also one major similarity. "They're two different worlds. But in both, we're trying to help people," he said.

Barnett still gets a chance to practice his old profession when he helps out at the Brookhaven Outreach Medical Clinic for indigent patients on Wednesdays when the legislature is not in session. He has also organized and flown a volunteer medical mission to Romania, where he said they administered medications and performed minor surgery. "Nothing major," Barnett said.

"It's been fascinating and very rewarding to try to help people," he said as he looked back on his careers as a physician and a legislator.

Although he's been in the Legislature a relatively short time, Barnett said session planning and operation have come a long way with the addition of computers at the Capitol. "I'm sending more e-mail now than I've ever sent, especially to the Senate," he said.

Now legislators carry lap-top computers that allow them to stay current on bills. Prior to getting the computers, lawmakers would be faced with stacks of bills on their desks.

And preparation for the 1997 session was especially good. Barnett said, "This was the best session we've had since I've been here. Summer committee meetings allowed lawmakers to plan legislation and work out details without having to take up time in session. It made the session run much more smoothly."

"You can't do that during an election year because you don't know who will be back," Barnett said about the planning sessions.

Barnett said the Legislature has some of the finest people to work with he has ever met. He said many lawmakers participate in good things like a Bible study every Tuesday morning. "You don't hear about things like that," Barnett said.

Speaking from the Capitol having come from a meeting of the Trauma Care Task Force, Barnett said serving in the Legislature often means long days. His usually last from around 7:30 a.m. to 6:30 p.m.

Possibly the first freshman to ever be appointed to the powerful House Appropriations Committee, Barnett said that work takes up a lot of his time in Jackson. He also serves on the Public Health and Welfare; Universities and Colleges; Game and Fish; and Conservation and Water Resources committees.

Other state duties Barnett can list among his credits are serving as chairman of the state Health Coordinating Council and as a director on the board of the Mississippi Economic Council.

But it is not only state business he deals with. There's some national work mixed in, too. With his medical background, Barnett is a member of the National Health Care Task Force and the American Legislative Exchange Council (ALEC). In ALEC, Barnett is vice-chairman for the state. The council, which is politically conservative, tries to develop model leg-

Jim Crawley Barnett, Jr., M.D.

Born: Edinburg, MS, 1926 to educator parents.

Graduated: Tylertown High School, attended Millsaps College, University of Mississippi School of Medicine receiving his M.D. from the Southwestern Medical College of the University of Texas in 1949.

Military: Served in combat as a navy flight surgeon with Fighter Group Fifteen during the Korean War.

Family: He and his wife Roberta, enjoy 11 children and 19 grandchildren.

Community Honors: For 12 years he was chairman of the Mississippi Aeronautics Commission. An avid flyer since 1945, he was chairman of the Brookhaven Airport Board several times, in 1986 the airport terminal was named the Jim C. Barnett Building in his honor.

Church: First United Methodist

What do you see as the most dangerous legislative issue facing physicians in the next few years?

"More and more government intervention, tort reform and the many paramedical people who want to practice medicine without the benefit of medical school."



islation for all 50 states. Some of the ideas in this year's welfare reform package came from ALEC models, Barnett said.

Concerning medical legislation, Barnett has made an impact by being available to answer the questions of the MSMA membership concerning medical issues and speaking up when necessary. With increasing government intervention in the practice of medicine, he said, "Physicians must become involved, either as members of the Legislature or by creating a close relationship with those who represent you."

When asked if he would encourage other physicians to run for state office, he replied, "Definitely yes! Physicians are very well accepted, both here and in Congress and also in national legislative organizations. Voters are pleased to be able to send someone to the Legislature who cares about people."

Having been on a conference call that morning regarding some national welfare reform issues, he said, "Physicians have to be involved! Whether you're a member of the State Legislature or not, be involved. And, don't you think for one minute that these guys down here on the floor don't listen to their doctors back home."

"Physicians have clout," Barnett said. "Other representatives come to me as a 'doc' and ask my opinion on health care legislation. I'm glad to give them my position but I do not jump up and speak on every health care issue that comes to the floor. Physicians should be more involved. When State Medical requests them to do something in regard to health care legislation they should respond. This is very, very important."

Barnett encouraged physicians, "You have more friends than you think you do. Even before I took office, if I called the Capitol in regard to medical legislation someone would call me back. I'd at least have a message by the end of the day." His other advice to membership, "Be a good listener. Consider and talk with the opposition about any issues that might arise."

He was also quick to tell physicians what not to do, "Don't bombard the legislator with hundreds of letters that obviously come from the same source and frequently the same postage machine. Physicians can avoid making these mistakes by calling their legislator personally. Leave your name and number with the Capitol operator or on their home telephone message machine and your call will be returned."

Barnett reiterated, "If physicians want to position themselves as a stronger political influence they should *get involved in all levels of government.* Make yourself known personally to the members of the Legislature. Contact your legislator and ask what you can do for him/her. Volunteer your knowledge of medicine to your legislator when medical issues arise."

What is the one thing you would like to see physicians do to be stronger advocates for medicine and patients?

"Listen to your patients' problems and respond with sincere care!" ***-Rep. Dr. Jim C. Barnett***



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H. Vann Craig, M.D.

The President's Page

One Hundred and Fifty Years of Care and Caring

This year the AMA is celebrating the one hundred and fiftieth year of its founding. A Code of Ethics was adopted at that first meeting and though modified slightly over the years still stands as the basis of conduct for our profession. That Code has been used as the proper relationship for other organizations around the world and if you read the fine print on most of your professional contracts and applications you are expected to adhere to that AMA Code of Ethics.

The AMA is the only organization that can represent the physician in the problems that affect our profession today. You may not agree with some of the AMA's policies. I doubt that there is a single physician that agrees with all of them. Perhaps it is because these policies have been hammered out on the anvil of Democracy. They first go to a Reference Committee where any member has the right to speak. They then go to the House of Delegates for a vote where I have seen an impassioned speech decide the outcome. In this foundry of physicians from all parts of our country, the policies of the AMA are created by consensus and majority vote.

If your fellow physician "friends" don't belong to organized medicine because of the cost of dues or if they don't belong because they don't agree with some small policy then they are CHEAP FREELOADERS who are not willing to give back a small part of what others are so willing to give in time and substance on their behalf. You may not like what I say, but that is the way I see it!

Ask them to join organized medicine and become involved with us for the betterment of our profession. Our solid front together is the only way our profession can survive.

Vann

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 9
SEPTEMBER 1997

Who is For the Patient?

Once again we face the decision of whether or not to start our own health maintenance organization as a state medical association. That the first attempt at this crashed and burned as a medical enterprise is well remembered and certainly bothersome. Somewhat more disturbing was the similarity in the debates that took place over each proposal. In each case, negative discussion centered on the personal costs involved, probably the easiest hurdle to overcome. More germane might have been some reflection over the resolve required to confront those of us expending too much money per illness, and if absolutely necessary to dismiss them from the program. Competitive pressures can be intense, you see, and the business interests permeating medicine could probably bring themselves to be at least as intense at cost cutting as could a group of doctors. Still hanging in the memory is the dazed look of shock and disillusionment on some member's faces when they learned that a gatekeeper was to be part of our first HMO proposal.

But some things do sound better this time. We are, after all, a great deal less naive about these sort of businesses than we were in the 80's. The surprises shouldn't be as stunning. Too, the enterprise would be vastly better funded, allowing a few mistakes in the inevitable learning process.

One of the best points about the new proposal was made by one of the originators when he stated that profits would be held down to the 1-2% range rather than the 25% seen elsewhere in the industry. Not only would a nominal profit give our program a competitive advantage if reflected in lower premium rates, but also it would help maintain a moral high ground.

And here's a better idea. How about no profit? Who needs it if the doctors are paid on a fee basis for the care they provide? With the profit motive gone, the HMO would avoid the criticisms that grow louder every month against managed care. Indictments are coming now in the Columbia/HCA investigation, and the situation there begins to remind one of the disaster for the nuclear power industry that began with the meltdown at Three Mile Island. High ground may prove to be valuable real estate.

And then might come the big prize — a law. A law that can only be dreamed of now. It might read something like this: In that land lying between the Mississippi and Tombigbee Rivers, and between the casinos on the south and Memphis and Shiloh to the north — the land known as Mississippi — there may exist managed care organizations and HMO's, but these shall be nonprofit only.

Who then would be for the patient? Only the real members of the health care team.

-Leslie E. England
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 9
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"They Said It!"

"All I can say is Hinds County hasn't missed a beat with out it."
Hinds County Coroner Robert Martin commenting on the States 2-year medical examiner vacancy.
"If the need were great enough, the state's top officials would have seen to it that the need was filled. It seems to me things run smoother when we don't have one."
Rankin County Coroner Jimmy Roberts who owns a mortuary where many autopsies are performed.
(*Clarion-Ledger*-6/28/97)

"Physicians in Vicksburg have the expertise and training to handle medical care provided in Jackson and by pooling assets here can make advances. Vicksburg, once the medical mecca of Mississippi, could again be at the forefront in the state. The medical history in Vicksburg is really a very important part of medical history in Mississippi."
W. Briggs Hopson, M.D., a surgeon and chief-of-staff at ParkView Medical Center in Vicksburg, speaking to the Vicksburg Kiwanis Club about the Merger of Vicksburg Clinic and the River Region Medical Corporation and Columbia Vicksburg Medical Center's lawsuit to have the merger declared a violation of federal anti-monopoly laws. The suit is on appeal to the U.S. 5th Circuit Court of Appeals.
(*Evening Post,* 6/18/97)

"We encourage them to bring their unused medicine into our office, and we take the labels off, but what we know is what it is. And when we have somebody who has to have it and there's no other way to get it, we give it to him. That's not the way it should be. It's not right, but we have to do what's best for the patient."
William Causey, M.D., an infectious disease specialist, talking about asking his patients to bring back unused AIDS drugs. A lack of funds has forced state health officials to cut 663 Mississippians from the HIV/AIDS drug assistance program.
(*Clarion-Ledger*- 7/6/97)

It's like that last yard to the goal line. One of the most important things is the use of immunization registries, which is a way of tracking kids so we can all keep up with when our children are due for their next shots. If we can do that for our dogs, we can certainly do that for our children."
Mississippi State Health Officer Ed Thompson, who attended a White House ceremony to mark surpassing the goal President Clinton set in his 1993 childhood immunization initiative. Mississippi has one of the highest children's immunization rates.
(*Clarion-Ledger*- 7/24/97)

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As physicians, our hearts have always been with our patients. Our mission saving lives.

Once this was enough.

Today, however, we are called upon to save more than our patients' lives. We are called upon to save their rights as well.

That's why I'm asking you to support the American Medical Association (AMA) as well as your state and local medical associations.

Together, we can achieve real and lasting changes. Already we have made great strides on behalf of our patients. Working together, we are educating a nation about the dangers of "gag" clauses, developing patient protection measures, and launching a wide spectrum of public health initiatives.

During Women In Medicine Month, we gratefully acknowledge the participation and support of all our female members. The AMA now has more women physicians than any other medical association. We encourage all female physicians, residents, and medical students to become members. So please, join now. Your patients' future rights and your entire profession depend on your commitment today.



"Let's keep our commitment where our hearts are. Behind our patients."

Support your patients and your profession. Join the AMA, and your state and county medical associations.

Nancy Wilson Dickey, MD
President - Elect
American Medical Association

American Medical Association
Physicians dedicated to the health of America

The AMA Celebrates Women in Medicine Month- Association Marks Observance with Groundbreaking National Women Physicians Congress

In recognition of the American Medical Association's (AMA) seventh annual Women in Medicine Month Campaign, scheduled this month, the Association will launch a national Congress for women physicians.

The AMA designates Women in Medicine Month, this year themed, "Women in Medicine- Breaking New Ground," to highlight the accomplishments of women in the profession and their increased numerical growth and significance in the medical workforce.

The national AMA Women Physicians Congress will focus on expanding the role and influence of women in organized medicine and the profession as well as addressing critical women's health and professional issues such as gender-based income disparities and the complexities of balancing professional and family responsibilities.

Women entering the medical field has fueled the growth in physician supply. Since 1970, the number of females has skyrocketed growing 425%, while the number of male physicians has grown 79%. Today, there are almost 150,000 women physicians comprising 21% of all U.S. physicians.

"Women are becoming more visible across the entire face of medicine," said Dr. Nancy Dickey, the AMA president-elect "This diversity benefits both patients and the medical community. Just as we need the perspective of several generations, we need the wisdom of both genders."

The AMA is the largest organization of women physicians' the nation and women continue to represent the fastest-growing segment of AMA membership, outpacing other demographic groups in both numbers and market share.

Membership among medical student and resident physicians is especially strong, reflecting the surge of women entering the field in recent years. Women comprise 42% of medical school students.

As women have entered medicine, they have moved steadily into leadership roles. Women serve on the AMA Board of Trustees, as presidents of their state, county and medical specialty societies and in the House of Delegates. The AMA Council on Long Range Planning and Development reports that the percentage of delegates who are women increased from less than 2% in 1983 to almost 9% by December 1996. In addition nearly 13% of alternate delegates were women.

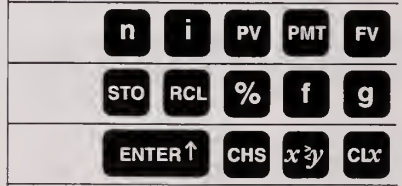
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Mississippi Attorney General Mike Moore Selected Recipient of *Dr. Nathan Davis Award*

Mississippi Attorney General Mike Moore, has been selected as a recipient of the American Medical Association's (AMA) *1997 Dr. Nathan Davis Award.* The award is the highest honor given by the AMA to a non-physician. It is presented "for outstanding contributions to promote the art and science of medicine and the betterment of public health." The awards, named for the founder of the AMA, will be presented at a recognition dinner in Washington, D.C. on September 30, 1997.

Through these awards, the AMA strives to encourage and stimulate public recognition for the highest standards of service throughout the levels of government. The awards underscore the significant accomplishments attained by men and women who are giving of themselves to advance the well-being of all. Attorney General Moore will receive the *Dr. Nathan Davis Award* in the category of elected official.

"State Attorney General Moore is certainly deserving of the award for his contributions to public health," said MSMA President Dr. Vann Craig. "He has made a major impact through his prosecution of drug crimes, support of drug education programs, as well as child and elderly protection legislation. Most recently, Moore has lead negotiations with the tobacco industry resulting in a $3.366 billion settlement for the state of Mississippi, litigation which has been called the most important public health litigation in the history of this country as over 420,000 Americans die each year from tobacco addiction."

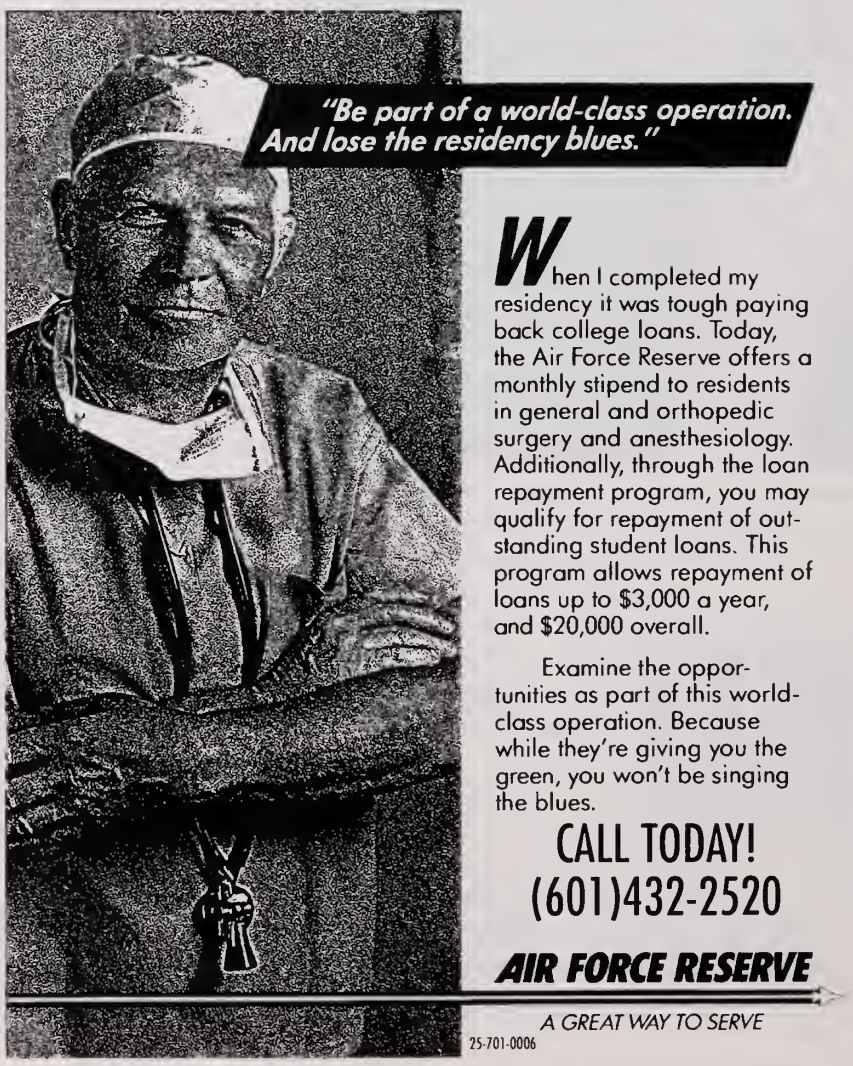
In his first bid for statewide office, Mike Moore was elected Attorney General of the State of Mississippi in 1987. Now in his third term, General Moore has concentrated on public health issues like drug prevention and education, Medicaid fraud, and elder abuse. He is

perhaps best known nationally for his famous litigation against the tobacco industry. Mike Moore was the first Attorney General to file suit against the tobacco industry on behalf of taxpayers to recover State expenses for treating tobacco-related illnesses. During negotiations with the tobacco giants, landmark admissions led the way for concessions on FDA regulation of tobacco as an addictive drug and cigarettes as a delivery method. Additional concessions from the tobacco industry to curtail marketing to youth came just days before the Mississippi Legislature passed the state's first major bill to deter tobacco sales to teens, a bill drafted and championed by Moore.

Born Michael Cameron Moore on April 3, 1952, Mississippi's Attorney General is the son of Hugh Moore of Bay St. Louis, Mississippi and Jane Lamar Moore of Lambert, Mississippi. He attended Our Lady of Victories High School in Pascagoula and then earned an undergraduate and a law degree from the University of Mississippi. He and his wife Tisha are the parents of one son, 10-year old Kyle.

Mike Moore has served as Chairman of the Criminal Law Committee and the Subcommittee on Elderly Civil Rights Issues, and representative to the Advisory Board of the National Resource Center for Child Advocacy and Protections for the National Association of Attorneys General of which he is also president-elect. He has also held posts on the Executive Working Group of Prosecutorial Relations and was Chairman of Mississippi's Substance Abuse Policy Council.

Mike Moore was tapped by the National Jaycees as one of *1992's Ten Outstanding Young Americans* for his drug prevention efforts. He was awarded the *1997 Wyman Award,* the highest honor bestowed by his fellow Attomey's General. The American College of Chest Physicians gave him the *Partnering in World Health Award* and the American Cancer Society recently honored Mike Moore with the *Distinguished Service Award* for his leadership in the fight against tobacco.



American College of Physicians and American Society of Internal Medicine Announce Merger Negotiations

The American College of Physicians (ACP) and the American Society of Internal Medicine (ASIM) have agreed on the principles that would form the foundation for a merger of the two organizations in the latter half of 1998.

Formal recommendations for the merged organization will be submitted to the Board of Governors and the Board of Regents of ACP and the House of Delegates and Board of Trustees of ASIM for approval this fall. Further negotiations between the two organizations will consider organizational, financial and legal issues related to a potential merger. The new organization, if approved, would be known as the American College of Physicians-American Society of Internal Medicine (ACP-ASIM.)

"The College is optimistic about the potential opportunities afforded by a unified voice for internal medicine that would combine the strengths of two outstanding organizations," said William A. Reynolds, M.D., ACP president.

"We look forward to further exploring the possibilities of a merger with the College," said M. Boyd Shook, M.D., ASIM president. "We're hopeful that our efforts will result in even more effective representation for our patients and internal medicine."

The American College of Physicians (ACP), founded in 1915 and headquartered in Philadelphia, is composed of more than 100,000 internal medicine physicians (internists) and medical students.

The American Society of Internal Medicine (ASIM, founded in 1956 and headquartered in Washington, DC, is a national medical association of 20,000 internists.

Both organizations provide information, education and advocacy for internists and their patients.

Internists are the major providers of continuing, comprehensive care for adults in the United States. All internists complete a three-year internal medicine training program after receiving their medical degrees. Subspecialty internists undergo one to three years of additional training in fields such as cardiology, oncology, gastroenterology, pulmonology, rheumatology, hematology, endocrinology, nephrology, infectious disease, and allergy and immunology.

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U.S. corporations have donated over $1 billion worth of their new products to nonprofits and schools over the past 20 years, according to a gifts-in-kind organization that collects and distributes these goods. Nonprofit hospitals, nursing homes, clinics, and health care agencies are eligible to participate in this nationwide giveaway, administered by the nonprofit National Association for the Exchange of Industrial Resources (NAEIR). Available supplies include office products, housekeeping supplies, maintenance items, paper products, clothing, computer software and accessories, toys and games, small gift items, tools, hardware, personal care products, and holiday party decorations. Recipient groups pay dues ranging from $275 to $575, plus shipping and handling, but the merchandise itself is free. Nonprofit directors choose what they need from 250-page catalogs issued every ten weeks. NAEIR says members receive an average of $2,000 worth of new supplies per catalog. Request NAEIR's free membership fact kit: 1-800-562-0955.

New Catalog Helps Obstetricians and Pediatricians Counsel Patients to Stop Smoking

From complete smoking cessation programs to pamphlets on secondhand smoke, a new catalog, developed in response to the AHCPR Clinical Practice Guidelines on Smoking Cessation, contains dozens of quality resources.

The catalog, developed by researchers in the field of smoking cessation at the University of Alabama at Birmingham, includes a host of state-of-the-art materials highly rated by health care professionals and patients alike. Free copies of the catalog can be ordered from the Wisconsin Clearinghouse for Prevention Resources at 1-800-322-1468.

For more information contact Suzan E. Winders, Ph.D., Associate Director, Smoke Free Families Technical Assistance & Dissemination Program, Assistant Professor of Medicine, Public Health and Psychology, (205)934-8960.

A Look at the Latest "Vogues" in Managed Care

There is no "grand unifying theory" of managed care," asserts Peter R. Kongstvedt, M.D., one of three experts contributing to "Health Plans en Vogue," the cover feature of the July/August 1997 issue of *Today's Internist*, the magazine of the American Society of Internal Medicine. The feature describes three emerging trends in the multifaceted, ever-changing world of managed care:

•**Open access to physicians**-Some plans are doing away with the restrictive, "gatekeepeer" model and allowing patients to go directly to a specialist. "This is what the public wants," says Anthony J. Kazlauskas, M.D., medical director of United HealthCare of New England, a pioneer of the open-access model. "People are demanding choice, as well as the opportunity to make their own decisions about their health care." However, Dr. Kazlauskas advises, "It's a wise thing for a patient to choose a primary care physician ... who can act as a coordinator of care."

•**Alternatives to capitation**-Capitated payments to physicians may not be the most effective way of controlling costs for chronic, high-needs patients, and some plans are exploring alternatives, including fee-for-service. Author Sandra E. D. McGraw, J.D., MBA, vice president of the Health Care Group in Plymouth Meeting, Pa., notes that these alternatives "pay a little more now [to physicians] to avoid paying a lot more later [to the hospital]." The bottom line is that "it is in everyone's best interest to avoid hospitalizing managed care enrollees with chronic care conditions," she writes.

•**Physician-friendly policies**-Health plans are redressing the bureaucratic hassles and changing the policies that have antagonized participating physicians and their patients. "As the managed care philosophy is incorporated into the mainstream practice of physicians, it becomes less necessary for health plans to micromanage," observes Dr. Kongstvedt, a partner in Ernst & Young's Health Care Consulting Service and principal author of the premier textbook on managed care. Dr. Kongstvedt, an encouraged members to seek physician involvement in four areas of clinical policy. He also exhorts physicians to "work together ... in organized systems" and "join the electronic age."

In another feature, health attorney Alice G. Gosf ield, Esq., presents an overview of the case law on liability in managed care, which she describes as a "risk-producing" environment. "The case law has not abandoned its focus on physician liability for failed clinical decision-making," she writes. Though some managed care organizations have faced liability for negligent selection of physicians, others have been able to preempt suits under the federal Employee Retirement Income Security Act, but that may soon change, Gosfield notes, as new legal arguments and corrective legislation develop.

Practicing internist Yul D. Eines, M.D., offers colleagues a practical approach to choosing and using an automated telephone system in practice. "It is possible to ... improve your practice's service, quality, productivity and economics without sentencing your patients to "voice mail jail,"' he writes, providing practical pointers. Dr. Eines, of Cranston, is president of the Rhode Island Society of Internal Medicine.

ASIM President-Elect Bernard M. Rosof, M.D., stunned at the way some health plans and institutions have promoted and reimbursed nurse practitioners as independent primary care providers, refutes the rationalizations behind this policy and offers alternative principles on medical assistance in patient care. Author of this issue's "Brave, New, IM World" column, Dr. Rosof is senior vice president in the department of medical affairs and medical director at Huntington (N.Y.) Hospital.

In his "in Focus" editorial, ASIM Executive Vice President Alan R. Nelson, M.D., offers some "self-defense measures" for physicians to avoid what he calls the "blunt instrument" of the Medicare fraud investigators hired by the Department of Health and Human Services Office of the Inspector General.

The Relationship Between Physicians' Malpractice Claims History and Later Claims: Does the Past Predict the Future?

There has been much debate on the interpretation of a physician's claims experience. It has been argued that a physician's past claims experience predicts future experience and that claims experience is related to quality of care provided. The purpose of this report is to provide an overview of articles that examine either the predictability of malpractice claims or the relationship between a physician's liability experience and quality of care. The studies reviewed yielded mixed results on the predictability of claims. Furthermore, the relationship between claims experience and quality of care was not firmly established.

These findings have implications for the National Practioner Data Bank that was established by Title IV of the Health Quality Improvement Act of 1986 (P.L. 99-660). Operational since September 1, 1990, the purpose of the data bank is to monitor physicians' claims experience. All payments made in settlement or judgment on behalf of a health care practitioner named in a written complaint about the care and/or services rendered must be reported to the data bank. Organizations such as hospitals, health maintenance organizations and group practices can access the information and use it to judge the quality and competence of individual physicians (US Department of Health and Human Services 1994).

Medical Malpractice Claims: Are They Predictable?

A relationship between past and future claims experience was found by many of the studies reviewed in this report. However, the interpretation of this finding varied from study to study.

Findings on claim predictability include:

An analysis of a malpractice data base from the Florida Medical Professional Liability claims file showed that past claims experience was found to predict future experience and past payments were found to predict future payments. Nearly half of the physicians who incurred very high payment claims in the period 1975-1980 incurred claims with payment in 1981-1983 (Sloan 1989).

Examination of claims data from the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that the hypothesis that past claims were a valid measure of an individual physician's future claims experience could not be rejected (Venezian 1989).

Data from the Medical Inter-Insurance Exchange of New Jersey, a physician-owned, medical society-sponsored malpractice insurer covering approximately 70% of the physician malpractice market statewide were examined. Claims filed between 1988 and 1989 were analyzed. On average, physicians incurring large numbers of negligence claims in the past were found to be more likely to incur large numbers in the future.

However, according to the authors, predictions about individuals based on past claims experience are probably not accurate enough to identify most claims-prone physicians (Rolph 1991). Claims closed between 1975 and 1988 were obtained from the Florida Medical Professional Liability Claims file and analyzed. In Florida, a physician's early claims history was statistically related to subsequent claims history; having any claims, whether paid or unpaid, small or large, single or multiple, put a physician at substantially higher risk of having subsequent claims (Bovbjerg 1994).

Analysis of Oregon state medical malpractice claims showed that having a claim in the previous year doubled both the likelihood of a claim in the following year and the likelihood that a claim results in a payout. The risk of a claim was found to increase following an initial claim, particularly in the subsequent year. Risk management education courses were found to have limited success in reducing claims and payouts and then only following an initial claim (Gibbons 1994).

Relationship Between Claims Experience and Quality

While there is some evidence that a physician's past claims experience foreshadows future experience, it is unclear whether claims experience is indicative of the quality of care provided by the physician. Several studies examined this issue and found the following:

•Board certification, a measure of quality, was

found to be associated with a higher claims rate. However, board certification may have measured the complexity of care provided by the physician and physicians with high payments may have provided more complex procedures. It was concluded that the empirical evidence did not demonstrate a relationship between claims experience and physician quality (Sloan 1989).

•Efforts to eliminate physicians with large numbers of claims may impact physicians who are simply more active rather than not competent. Because of the wide variation found in the claims experience of physicians across different specialties, policies that are not specialty specific would restrict practice of very large fractions of some specialties while leaving other specialists unaffected (Venezian 1989).

•Florida obstetricians, practicing in 1987, who lost, settled, or defended malpractice claims between 1977 and 1983 were analyzed. The results indicated that using claims experience to identity physicians at risk of future clinical errors may lead to misjudging the likelihood that substandard clinical care will be provided by physicians (Entman 1994).

•Claims against physicians insured by the Medical Inter-Insurance Exchange of New Jersey over the period 1977-1989 were examined in an effort to identify potentially preventable sources of medical injury in obstetrics/gynecology, general surgery, anesthesiology, and radiology. Patient management errors, including errors in diagnosis, medication errors and unnecessary treatment, were found to be the most frequent type of errors committed. These errors, compared with technical performance and coordination problems, were found to be associated with greater mortality and higher indemnity payments.

It was concluded that malpractice data could be used to identify problem-prone clinical processes and suggest interventions that may reduce negligence,(Kravitz 1991).

•Claims filed in New Jersey and closed during the period 1977 to 1991 were used to determine whether the large variation in malpractice claim experience across specialties could be explained by differences in physician performance. Physician performance was assessed using two criteria: The presence of a plaintiff award and whether the physician's patient care was considered indefensible by the physician's insurance company. Despite large differences in claims frequency, most specialties were found to have similar percentages of awards and indefensible cases. Variation in claims rates by specialty resulted from factors other than differences in physician performance (Taragin 1994).

Summary

Although there was some disagreement on interpretation of the results, most of the studies summarized here found some correlation between past and future claims experience. However, as noted in one study, there is a big difference between knowing that physicians are more likely to incur claims and being able to identify who those physicians are. Among characteristics of physicians found correlated with claims experience, specialty was the most often cited. Most of the studies found no significant relationship between claims experience and the quality of the provider.

Some of the studies expressed concern about the potential uses of the National Practitioner Data Bank. Some studies warned that Data Bank information could not reliably be used to identify physicians likely to make errors. One study noted that linking physicians' malpractice experience with their quality of care would require more information than could be derived from a closed claim data set. Examples of data necessary to perform such an analysis included information on patient-physician relationships and practice-specific information regarding procedure and patient mix.

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Income Up For Specialty Physicians, Down in Primary Care, Survey Shows

Reports of the demise of medical specialists and of solo practice may have been premature, a new survey suggests.

Based on a review of 1, 664 physician recruitment assignments conducted by Merritt, Hawkins & Associates, an Irving, Texas based health care staffing firm, income offered to recruit medical specialists increased in the last year, while income offered to some primary care physicians declined.

In addition, the percentage of searches Merritt, Hawkins & Associates conducted for primary care physicians decreased, the first such decline since the firm began compiling its annual review four years ago. By contrast, the percentage of searches for medical specialists and physicians in solo practice settings increased, the first such increase the firm has seen in four years.

All of these developments indicate a stalling of managed care driven trends in physician recruitment, according to Joseph Hawkins, Merritt, Hawkins & Associates' Chief Executive Officer. "Managed care is supposed to be depressing incomes for specialty physicians, increasing the need for primary care physicians, and reducing the viability of solo practice. None of these trends is evidenced in this year's survey."

A Market "Catching Its Breath"

Are specialty physicians and solo practice making a comeback? Possibly, says Hawkins.

"Managed care has churned the market for physicians like a twister," Hawkins states. "The last twelve months may have been a lull where the market paused to catch its breath."

Hawkins sees the increased demand for medical specialists as a reaction by health care providers who have aggressively recruited primary care physicians and are now rounding out their physician panels with specialists. "The rush to establish primary care networks led to a lag in specialty recruitment," Hawkins says. "The need to catch up and the increased popularity of point of service HMOs and other products that increase access to specialty physicians is driving the need for specialists."

Solo practice also has rebounded, Hawkins states. "An increasing number of medical specialists are seeking solo practices in non-metropolitan areas to boost their incomes and protect their clinical autonomy," he notes. "Many smaller communities are happy to have them."

Income, Bonuses and Loan Forgiveness

Other results of the survey: Searches in primary care (family practice, general internal medicine, pediatrics) made up 65.8% of all searches Merritt, Hawkins & Associates conducted in 1996/97,down from 72.5% in 1995/96. The numberof searches the firm conducted for specialty physicians grow by 51% over the previous year, while searches for primary physicians grew by just 12%. Searches for physicians in solo practice settings increased from 15% of all searches in 1995/96 to 20% of all searches in 1996/97.

Income offered to recruit family practitioners dipped from an average of $131,000 in 1995/96 to an average of $129,000 in 1996/97. Income offered to pediatricians also slipped, from $126,000 in 1995/96 to $125,000 in 1996/97. Conversely, income offered to recruit general internal medicine practitioners climbed from $135,000 in 1995/96 to $141,000 in 1996/97, the only gain seen in primary care.

"The demographics are right for internal medicine," Hawkins states, "as the senior population internists generally treat continues to grow."

Signing bonuses are an increasingly utilized recruitment incentive used in 26% of all 1996/97 searches, up from 24% in 1995/96. In addition, the average amount of bonuses increased from $11,000 in 1995/96 to $15,000 in 1996/97.

Forgiveness of educational debt also is increasingly used as an incentive. Debt forgiveness was offered in 15% of 1996/97 searches, up from 13% in 1995/96. With some physicians owing $100,000 or more in student loans, debt forgiveness can be an attractive incentive, Hawkins says.

Allied Takes Off

This year marks the first time Merritt, Hawkins & Associates has included incentives for allied health professionals such as physician assistants, physical therapists and registered nurse practitioners in its review. The demand for these professionals led the firm to open a new division in 1996, MHA Allied Health Care Search. "Allied health professionals fill a key role, particularly in managed care environments, because they provide relatively inexpensive services" Hawkins notes. "Increasingly, they are being used not just in clinic settings, but in the hospital."

For a free copy of MHAs' 1997 Review of Physician Recruitment Incentives call (800) 876-0500 or access the firm's Web site at http://www.practice-net.com.



Left to Right: Karen Long Manning, M.D.; Kathy Travis,M.D.; AMA Board of Trustees Member J. Edward Hill, M.D. and AMA Resident Physician Section Delegate Tammy Young, M.D..

AMA Honors Drs. Karen Manning and Kathy Travis for Outstanding Community Service

Karen Long Manning, M.D., a resident in family medicine and Kathy Travis, M.D., a resident in internal medicine, at the University of Mississippi Medical Center (UMC), were honored by the American Medical Association (AMA) during its Resident Physician Section Annual Meeting in Chicago.

They were two of 40 resident physicians from around the United States who were honored as part of the AMA/ Glaxo Wellcome Leadership Award Program.

This program was established by the AMA in 1988 to honor resident physicians who display leadership and a strong commitment to the health of their patients and the community as a whole through community service outreach.

Dr. Manning has volunteered for the past five years in Sports Physicals day for local schools helping perform pre-participation sports physical exams for students. She has been involved in the Tar Wars programs, a tobacco education program for elementary school children, speaking in several schools and has coordinated other related programs among her fellow residents. Dr. Manning serves on the UMC's Recruitment and Selections Committee to actively promote and recruit primary care physicians.

Dr. Travis has volunteered for blood pressure screening at a senior citizen center and served as the student director of a volunteer emergency medical service in a small mountain community, near Sewanee, Tennessee. She served as co-chair of the Hope House project and organized volunteers to paint and refurbish a home for cancer patients who traveled to Jackson for outpatient treatment. She participates in the Junior League mentoring program and meets twice a month with inner-city girls organizing educational, social and recreational activities.

"Our goal is not only to honor medicine's future leaders, but also to encourage them to bring their strengths to bear on the future health of our patients and health care system by getting involved in organized medicine," said Daniel Johnson, M.D., AMA President.

The AMA/Glaxo Leadership Program was developed with a grant from pharmaceutical manufacturer Glaxo Wellcome, Inc. The Program will honor 40 residents again in 1998.

Dr. James McIlwain Named Foundation President

Dr. James S. McIlwain Jr. of Clinton has been named president of the Foundation for Medical Care. Dr. McIlwain currently serves as principal clinical coordinator, a position he will hold as the Foundation continues as the peer review/quality improvement organization for the state.

His dual positions represent a first for quality improvement organizations, which are federally designated entities in each state charged with assuring quality medical care for Medicare beneficiaries.

"Dr. McIlwain brings to this new position both the clinical and managerial skills necessary to carry the Foundation into the 21st century," said Dr. L. H. Brandon of Starkville, chairman of the Foundation board of directors.

Some 2000 physicians represent the membership of the Foundation, which implements the Health Care Financing Administration's Health Care Quality Improvement Program. Projects designed to improve quality of care involve Mississippi hospitals and physicians in gathering and analyzing data to determine best medical practices. Medicare recipients also benefit from Foundation information concerning their health care.

"As we continue our Health Care Quality Improvement Projects in such studies as the national Cooperative Cardiovascular Project as well as stroke, atrial fibrillation and diabetes projects, we will continue to focus on vital health care issues and keep the health of all Mississippians uppermost in our vision and mission," said Dr. McIlwain.

Foundation Presents Quality Awards to Mississippi Hospitals

The Foundation for Medical Care presented annual quality awards at the 1997 Mississippi Hospital Association's Health Care Exposition and 66th Annual Leadership Conference held in Biloxi June 23-27.

Baptist Memorial Hospital-Golden Triangle Inc. in Columbus was named the recipient of the third annual Award of Excellence given for exceptional achievement in continuous quality improvement projects.

Alton B. Cobb, MD, MPH, clinical coordinator for the Foundation's Health Care Quality Improvement Program, presented the award to Brenda Bell, director of volunteer services, and Christina Brown, marketing manager for Baptist Memorial. Dr. Cobb praised the hospital, "Baptist Memorial, winner of the Award of Excellence for the third consecutive year, has shown significant improvement in the care of their patients with heart attacks, strokes and diabetes, through their continued dedication to quality improvement efforts."

Also, Dr. Cobb recognized Biloxi Regional Medical Center as recipient of the third annual Special Recognition Award given for outstanding achievement in a single quality improvement project. Accepting the award were Jean Cooper, department director of quality management, and Bonnie Stewart, project coordinator. Dr. Cobb recognized Biloxi Regional for accomplishments in quality improvement efforts relating to the care of patients with heart attacks and intervention for the prevention of strokes through its involvement in the national Cooperative Cardiovascular Project.

Dr. Cobb presented three Mississippi hospitals with an Award of Merit for their quality improvement efforts. Accepting the awards were: Thomas Bland, administrator of Montfort Jones Memorial Hospital in Kosciusko; Chip Camp, associate administrator of Delta

Regional Medical Center in Greenville; and Robert Hammond, executive director and chief operating officer for River Oaks Health System in Jackson.

Dr. Cobb recognized each hospital's improvement, stating, "Montfort Jones has implemented a treatment policy for acute strokes that meets the American Heart Association's recommended policy. Delta Regional has dramatically improved in its use of thrombolytics and other appropriate medications in the treatment of its post myocardial infarction patients. River Oaks has improved its compliance rate for using preventive antibiotics before surgery to near 100 percent."

Lee Drake, M.D. has joined the Birth Center at Methodist Hospital as a part of its medical staff. Dr. Drake was formerly in private practice in Amory.

Harold Hudson, M.D., of Tupelo is now affiliated with the West Point Nose and Throat Clinic. Dr. Hudson completed medical school at the University of Mississippi and a residency at the University of Mississippi Medical Center. He joined the staff of North Mississippi Medical Center in 1973 and is certified by the American board of Otolaryngology.

Emile M. Baumhauer, Jr., M.D. announces his retirement from active practice from Pascagoula Family Practice.

George McGee, M.D. and Joe Washburne, M.D. are two physicians featured in a video developed by Mississippi Medical Management, a subsidiary of Wesley Healthcare System Inc. The long-form video is used to recruit new physicians to the area. The award-winning video (first place in the category of Professional Recruitment Advertsing in the 14th annual Healthcare Advertising awards) showcases the Hattiesburg area, Mississippi and the local medical community. In the video, Dr. McGee and Dr. Washburne discuss the quality of life in Hattiesburg, growing healthcare opportunities in the area and their personal decisions in choosing Hattiesburg for their practices. Also featured in the video is a long list of accomplishments achieved by the area and the medical community, including: "America's Most Livable Small City", and a No. 2 ranking in the South and a No. 1 ranking in healthcare in the nation in *The Rating Guide to Life in America's Small Cities* and Methodist Hospital's accreditation with comendation from the Joint Comission on Accreditation of Healthcare Organizations, which places Methodist among only four percent of the hospitals nationwide to receive that distinction.

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Patrick Hsu, M.D., a Corinth obstetrician/gynecologist, has claimed one of the first voluntary board recertifications in North Mississippi. Dr. Hsu recently earned his recertification by the American Board of Obstetrics and Gynecology. He also fulfilled the continuing medical education requirements to claim the Physician's Recognition Award of the American Medical Association. Dr. Hsu was originally certified in 1985 when the board was encouraging physicians to be recertified every 10 years. The American Board made recertification mandatory in 1996 but Dr. Hsu was grandfathered in and recertification wasn't required. That's why it is called a voluntary recertification.

Christopher Ball, M.D. has been elected Methodist Medical Center's chief of staff-elect for 1997. Dr. Ball, who joined Methodist Medical Center's Clinic for Women in 1985, received his Doctor of Medicine degree from the University of Mississippi's School of Medicine in 1981. He completed his internship and residency at the University of Alabama in Birmingham where he was chairman of the Junior Fellows of the American College of OB/GYN for the state of Alabama. Dr. Ball serves as president of the Jackson OB/GYN Society and is a past president of the Jackson Gynecic (OB/GYN) Society. He is board certified and a fellow of the American College of Obstetrics and Gynecology.

Robert N. Gilliland, M.D.'s portrait was unvailed in ceremonies at Montfort Jones Memorial Hospital. Dr. Gilliland has retired following almost 40 years of medical practice in Kosciusko and the portrait will hang with those of other physicians. Following the unveiling, hospital personnel honored Dr. and Mrs. Gilliland at a reception.

Walter Eckman, M.D., a Tupelo neurosurgeon, was the first in the state to be trained in the use of the new MicroEndoscopic Discectomy System, the brand name of the equipment developed by Sofamore Danek in Memphis. A Hattiesburg physician has since begun offering the service. Eckman said the new surgical equipment makes repairing herniated, or slipped, discs that may be pinching a spinal nerve less invasive, and patients report fewer recovery problems and pain. Dr. Eckman operates the Aurora Spine Centers in Tupelo and Jackson.

David C. Stout, M.D. has completed requirement for certification as a diplomate of the American Board of Urology. Dr. Stout received his medical degree from Louisiana State University Medical Center School of Medicine in Shreveport where he also completed an internship and residency in urology. Dr. Stout practices at Hattiesburg in association with Drs. Matthew Fray, Richard Johnson and Randolph Ross.

Noel K. Hunt. M.D., and **Hans Noffsinger, M.D.,** internal medicine physicians, have joined North Mississippi Health Services IMA Foundation with the opening of a regional clinic in Booneville. IMA of Booneville opened July 14 at 1301 North Second Street. It is located in the building that also houses the Booneville Family Medical Clinic. Dr. Hunt is a graduate of Iuka High School and the University of Mississippi. He completed his medical studies at the University of Mississippi School of Medicine. He comes to Booneville from the University of Tennessee, Memphis, where he recently completed his internal medicine residency. Dr. Noffsinger completed his undergraduate studies at the University of Kentucky and received a doctor of medical dentistry from the University of Kentucky College of Dentistry. After several years in private practice, he returned to medical school and graduated from the University of Kentucky College of Medicine. He recently completed his internal medicine residency at the Chandler Medical Center, which is affiliated with the University of Kentucky.

F. Alan Covin, M.D., FACC, Hattiesburg's newest cardiologist, has joined the HubSouth Medical Clinic on the Methodist Hospital campus. Dr. Covin completed his training in cardiovascular medicine at the University of South Alabama Medical Center in 1994 and practiced in Baldwin County, Alabama, before relocating to Hattiesburg. A native of Evergreen, Alabama, Dr. Covin graduated from the University of South Alabama College of Medicine and completed his internal medicine residency at the University of South Alabama Medical Center in 1985. He is board certified in both cardiovascular diseases and internal medicine.

John McFadden, M.D. of the Tupelo Pain Clinic was a guest speaker at the Northeast Mississippi Branch of the Lupus Foundation of America's meeting in New Albany. He spoke to the group about acute and chronic pain management. He is currently doing research on pain involved with Fibromyalgia.

Ralph H. Didlake, M.D. was recently elected president of the Mississippi Chapter of the American College of Surgeons.

Placement Service

Attention: MSMA Members

The **JOURNAL MSMA** is seeking manuscripts that have not been previously published and are not under consideration by any other publication, submitted in accordance with the guidelines for authors. Articles of medical, socio-economic nature as well as articles of local appeal relative to medical practice in Mississippi are of particular interest. Manuscripts are subject to the reviewing process by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to **JOURNAL MSMA** readers, and usefulness or importance to physicians. Authors are notified upon acceptance or rejection of their manuscript. Contact the managing editor with any questions concerning submission guidelines. Address all correspondence to the Editor, **JOURNAL MSMA**, P.O. Box 5229, Jackson, MS 39296-5229. Phone:(601)354-5433, extension 412.

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Congressional Budget Office: In a 1996 report on deficit reduction, the CBO warned that with across-the-board cutting in Medicare, some beneficiaries "*...might find that they no longer had access to some medical services in the traditional fee for service sector.*"

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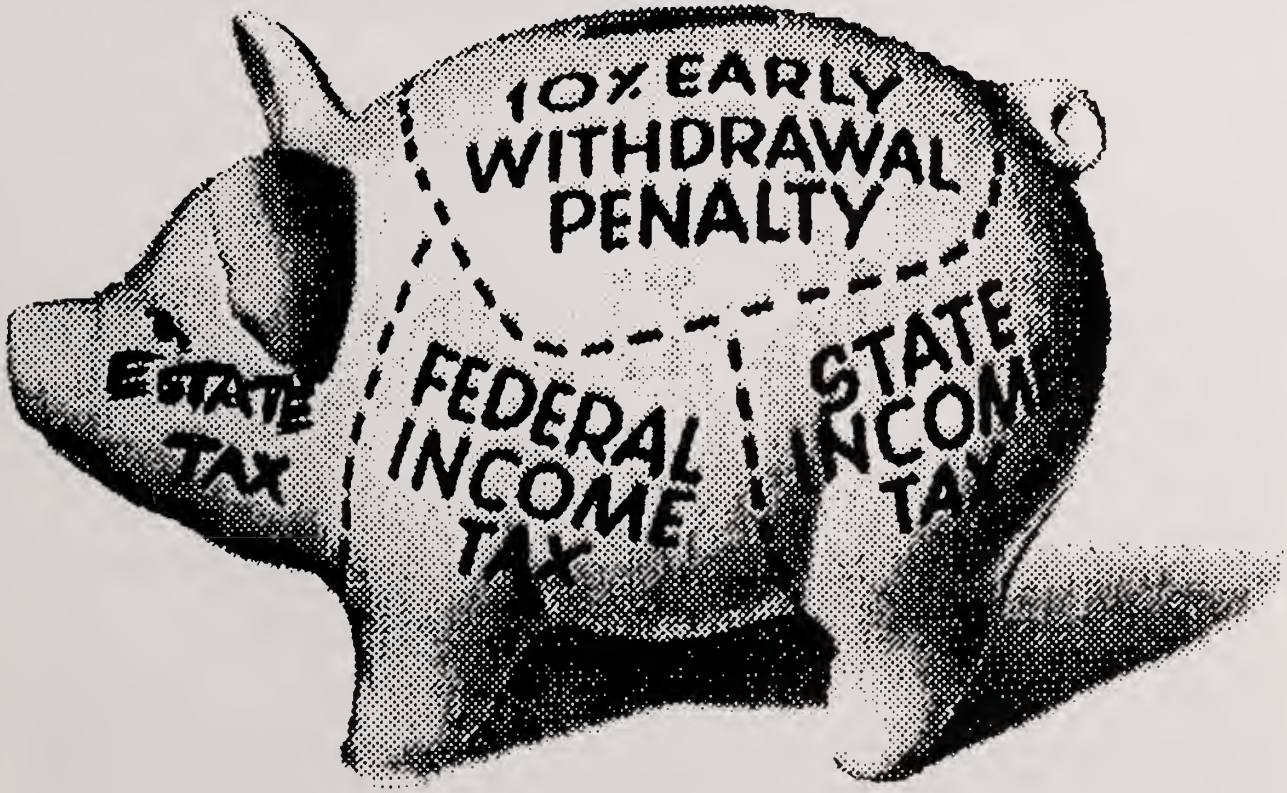
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Medicine in Antebellum Mississippi

Lucie Robertson Bridgforth

The slightly more than four decades between 1817, when Mississippi entered the Union, and 1861, when it abruptly departed, have received a variety of labels, depending upon the perspective from which the period is viewed. In retrospect from the great internal war that tore the nation apart between 1861 and 1865, these halcyon days constitute the antebellum era, the Golden Age of the Old South. From an economic point of view, these were the Flush Times during which the cotton kingdom rose and the frontier rapidly expanded. An analysis of society during these years might suggest that this was an Age of Reform, characterized by widespread efforts of both a Utopian and practical nature to perfect the social order. Politically, this was the Age of the Common Man, marked by the spread of democracy and dominated by the influence and the image of Andrew Jackson. But as for the physical well-being of the citizens of the nation, these were the Dark Ages of American Medicine.

Actually, as far as they go, each of these descriptions is accurate. Each emphasizes factors that played an important part in determining the contours and the course of American medicine in the early nineteenth century. Even in today's antiseptic, highly technical world, medicine cannot be extricated from the political, social, and economic milieu in which it exists. Certainly in the years that preceded the triumph of scientific medicine, health care was more often determined by the whims of nature and the attitudes of society than by the received truths of a respected medical profession. Those whims and attitudes form the foundation on which the story of medicine in antebellum Mississippi is built.

"Let us begin by discussing the weather," suggested historian Ulrich B. Phillips in his well-known study of slavery, *Life and Labor in the Old South*. A study of health care has the same starting point, for it was the weather and the land that created the unique health conditions that marked the Old South. Particularly in the Southwest, that is, the lower Mississippi River Valley, did the environment play a central role in the physical well-being of inhabitants until well into the twentieth century. In the antebellum period this was a frontier region, just beginning to open to white settlement as the Indians were removed and states were formed. Geography, however, set this region apart from other American frontiers. The long, hot, humid summers made the production of large-scale staple crops highly profitable, and thus the plantation system for which the Old South is so renowned, and with it the institution of American Negro slavery took root. The land remained isolated and sparsely settled, characterized by thick vegetation and a semi-tropical climate.

Such was the insalubrious setting that greeted all who chose to locate in the area that became the state of Mississippi in 1817. Awaiting those pioneers were myriad

medical problems, many of which were indigenous to the Deep South and others that faced all the inhabitants of the early American republic. For Mississippi's first citizens, life was precarious at best. The numerous factors that militated against good health took an exacting toll, both in lives and in productive activity. That the Deep South posed special hazards is evident both in the statistics of death rates kept at that time and in the fact that life insurance premiums were higher for southern clients.[1] That the region was able to develop an advanced economic and political order in spite of these hazards is quite remarkable.

To begin with, problems arose from the crude living conditions that often left these early settlers overexposed to the elements, especially in the winter, and subject to the severe respiratory diseases that were the nation's foremost killers in the nineteenth century. Nutritional inadequacies rendered many chronically debilitated, while contaminated food and water produced such further complications as developmental disorders and intestinal diseases. The marshy river lowlands were so hospitable a breeding place for mosquitoes that malaria came to be accepted as a matter of course. In addition to these common and usually unavoidable distresses, inhabitants of the region were visited periodically with dreadful epidemic diseases brought in by travellers, usually from the river. Smallpox, which was both disfiguring and deadly, invaded antebellum Mississippi on several occasions, as did the "devastating pestilence" Asiatic cholera, which often claimed its victims within twenty-four hours after the onset of illness.[2] Appearing more frequently was yellow fever, the exotic insect vector disease that swept up the river with a vengeance during the summertime. In the few towns that developed as the area became more populous, especially the Old Natchez District, close living quarters presented other dangers because of the absence of any public sanitation and the recurrence of such serious contagious diseases as diphtheria and measles.[3]

But it was not only the frontier conditions and the unhealthy climate of antebellum Mississippi that accounted for the frequency of illness and the omnipresent threat of early death. The competency of the medical profession and the level of medical knowledge, the two factors upon which the social control of disease depended, did little to ameliorate the situation. The hot, humid, rural region so described could attract to its borders few sophisticated, well-trained medical minds. Those who did come were often disillusioned by what they discovered when they arrived. Solomon Philips, for instance, a New York-educated physician who migrated south in the early nineteenth century, managed to acquire extensive landholdings during his sojourn in Mississippi. But he found the "inhospitable clime" of the region to be so distasteful that he urged the heirs to his estate never to "remove or settle on the land or anywhere in the baneful influence of the vast Mississippi swamps." "Stranger, beware," his tombstone warned. "I left my native home, I found no better, but found a tomb."[4]

Without doubt physicians were needed in the new southern states, especially as the population increased, but in these early years when the republic was growing rapidly everywhere, the demand for physicians far outran the supply. The resulting gap left a great deal of room for pretenders. Those who practiced the art of healing included barbers and apothecaries, midwives and housewives, ministers and overseers, and the flamboyant medicine man. Yet even the relatively few really high-quality American physicians, who had been formally trained in one of the American medical colleges or had been afforded the advantage of a European education, were still severely limited in their capabilities.

It is important to remember that what any school child of today knows about bacteria and viruses was a mystery to the best minds of the early nineteenth century. Although by then great strides had been made in the understanding of such basic biological sciences as anatomy and physiology, little was known about the nature and course of infectious and contagious diseases. However, most medical practitioners lagged far behind the pure scientist. This lag was exaggerated in the South because of the lack of transportation and the scarcity of major urban areas hindered the dissemination of knowledge. The age-old diseases and disorders that had plagued mankind since time immemorial continued to move unabated through the Southland with discouraging regularity, while men still looked for causes in all the wrong places.

During the formative years of the republic there was no substantial body of useful medical information. As a result physicians relied not on the certainty of knowledge but instead on the probability of theories. Few of these theories, however, held any medical validity or any scientific basis. Consequently there was for the most part no relationship between theories and actual diseases. The most widely held theory of the period mistakenly perceived the etiology of disease to lie in one fundamental biological principle. The giant of eighteenth-century American medicine, Benjamin Rush, often called the American Hippocrates, reinforced this belief in a monistic pathology, maintaining that the underlying cause of all illness was vascular tension.[5]

In the absence of any medically valid theories, there were few medically valid therapies. Diagnosis was inaccurate, prophylaxis was insignificant, and treatment was based on conjecture. Prior to the advent of scientific medicine in the late nineteenth century, even the best trained physician approached his patient without any real confidence that his remedy would do more good than harm. Most subscribed to the position that if disease derived from one fundamental source, all maladies could be remedied with similar panaceas. Accordingly, physicians believed the proper treatment for almost all illnesses to consist of several routine steps, most of which induced quick alterations in external symptoms.

Foremost among these steps was bloodletting, an antiphlogistic treatment that caused fever to pass and was applied for everything from burns to fractures. Equally important was a thorough cleansing of the body through the ingestion of powerful chemical purgatives and emetics. Drugs, including both mineral and botanical compounds, were also frequently used. Skin irritants were applied externally to raise blisters and release harmful matter from the body through the flow of pus. These measures were often followed by a variety of restorative tonics, including quinine, which was truly effective in the treatment of malaria.[6] As drastic as this "heroic medicine" was inherently, making it even more dramatic was the excessive manner in which these procedures were administered. As Rush argued, "desperate diseases require desperate remedies."[7] Bleeding, for instance, might involve drawing as much as fifty ounces of blood from the body. The drug calomel, which is a chloride of mercury, was a widely accepted cathartic often given in doses massive enough to be lethal over a period of time.[8]

There is abundant evidence that Mississippi physicians, regardless of their level of training, applied all of these tactics. Planter-physician Martin W. Philips, for instance, recorded dosing a sick slave with a combination of twenty grains of calomel, two grains of the emetic ipecac, and one grain of opium.[9] When Asiatic cholera swept through the state in 1849, attacking with particular virulence the slaves in the river counties, victims were treated first with "heating" medicines such as cayenne pepper, camphor, and peppermint to bring on sweating, then with calomel to unlock the liver so that the bile could flow.[10] These oral medications were followed by a "hot mustard foot bath, hot bricks to the feet, large plasters of mustard over the abdomen, and thighs and legs." Next came bloodletting, provided the skin was warm and the pulse firm. Finally there was a "brandy toddy," which was also used as a "preventive to disease [when] burnt in spices."[11]

There was, to be sure, a lack of complete agreement over the benefits of heroic medicine. Surprisingly, enough patients survived these treatments for even intelligent men, especially those who placed theory over humanity to extol the benefits.

One proselyte told of a "dying, cold as ice, pulseless and speechless" man who "jumped up and was walking about" within a half hour after he had received calomel in one hundred-grain doses.[12] A reviewer in the Western Journal of Medicine and Physical Sciences praised the "great boldness and energy" of the medical instance, practitioners of the lower Mississippi Valley, who relied on the lancet and calomel as their "anchor of hope."[13]

Skeptics, however, quarreled with these drastic measures, urging moderation if not abandonment of such tactics. No doubt this dissent among the mainstream of medical practitioners, coupled with the obvious dangers and shortcomings of their therapeutics and theories, led many in the antebellum South, as elsewhere in the country, to reject the orthodox practitioner. In droves people turned instead to the potions and programs hawked by a host of medical imposters and sectarians who sprang up in the rapidly growing nation to offer alternative solutions to the recurring maladies that threatened them.

To understand the willingness of the American public to buy into these "quack" solutions, it is necessary to keep several factors in mind, including the traditional gullibility of the American public and the natural workings of the free enterprise system. The idea of a quick fix, rational or not, still appeals to those who demand an easy solution for every problem. But more importantly, the helplessness of nineteenth-century man in the face of dangerous disease rendered him particularly susceptible to the medical con man. Confronted with continuous irritating and periodically devastating health problems, people were willing to try almost anything. On a daily basis, concern with health occupied private thoughts. In the face of epidemic, concern for health became a matter of public urgency.

It is quite difficult to imagine a disaster short of earthquake or war that would in today's sterilized, painless world disrupt social, economic, political, and private life so thoroughly as did the major epidemics that moved frequently and freely through antebellum America. Every facet of life was affected. Panic was the order of the day. Newspapers warned people to take preventive action and published advice concerning remedial measures. Public officials attempted to impose quarantines. Families that could afford to do so uprooted in search of more salubrious locations. Even slaves were removed to protect the economic investment of the planter.[14] Those who re-

mained to challenge a disease on the rampage, including the physicians who stayed to help the victims, risked personal tragedy. During America's first cholera epidemic in 1833, for instance, the town of Vicksburg reported up to forty new cases a week. Among the fatalities were the three daughters of Dr. J. W. Hegeman, one of whom died along with her fiance on their wedding day. The governor of Mississippi, Abram Scott, was also a casualty of cholera that year.[15]

During a serious epidemic public life literally came to a halt. The government of the state either shut down or moved from the capital to a safer site. As late as 1897 the University of Mississippi remained closed for the first two months of the academic year because of the presence of yellow fever in the region, only to discover reduced enrollment when the school finally opened.[16] Financial losses created widespread economic hardship in the wake of epidemic disease, for businesses were forced to curtail their operations, productive activity was sharply reduced, and lives were lost. When cholera struck again in 1849, Dr. Stephen Duncan of Natchez, a physician-planter who should have been more able than most to cope with the disaster, lost 133 field hands and his entire cotton crop for the year. Other planters lost up to two-thirds of their slaves.[17] Such a heavy toll in no way indicates that slaves were medically deprived, for they usually received the same level of care as whites, but instead emphasizes the impotence of men in the face of disease.[18]

The obvious need for medical help in early nineteenth-century America, matched by the inadequacies of orthodox doctors, encouraged the development of a variety of medical sects. The rise of these sectarians, who were resented and scorned by the regulars, was one important reason why the antebellum period is often termed the Dark Ages of the Medical Profession. But in all fairness it must be remembered that their various programs , which often advocated clean, healthy living and natural remedies, were scarcely more injurious to the patient than heroic medicine. No doubt these sects would not have been so popular had not the general public so distrusted the regulars.[19] Of these sects there were three that gained particular popularity in Mississippi: homeopathy, hydropathy, and Thomsonianism.

Homeopathy, a theory developed by the German Dr. Samuel Hahnemann, was predicated on the belief that whatever substance induced the symptoms of a disease would also cure that disease if administered in infinitesimally small doses. Eventually adherents to this theory became so influential that they established separate hospitals and a national medical organization. Into the twentieth century they continued to compete rather successfully with the regulars. Since their tactics in effect allowed nature to cure the diseased, their methods often times produced successful results.[20] Consequently homeopathy attracted to its folds a number of educated physicians who were disillusioned with heroics.

Dr. William Holcombe of Natchez, for example, began practicing medicine by working with Dr. F. A. W. Davis, a trained physician who had been converted to homeopathy. During the yellow fever outbreak of 1853, Holcombe and Davis claimed that 33 patients, as opposed to 430 deaths among the patients of the city's orthodox practitioners. The two homeopaths subsequently received substantial public support and were placed in charge of the Mississippi State Hospital in January 1854, where they sharply reduced the death rate by forbidding the use of "bleeding, purgatives, calomel, blisters or other allopathic measures."[21]

Another important sectarian group were the Thomsonians, who had become popular enough by 1835 for the governor of Mississippi to proclaim that half the state supported the Thomson system.[22] Founded by the self-taught Samuel Thomson, this system was touted as being more effective, more convenient, and less expensive than orthodox medicine. Thomsonians advocated that illness should be treated with botanical and other natural remedies and steam baths. They also championed the cause of sound dietetic practices and preached against the evils of alcohol and tobacco. In this respect they reflected the reform spirit of the time, especially the temperance crusade, and also illustrated the widely held belief that disease was associated with sin.[23]

Thomsonianism swept rapidly through rural antebellum America as disciples spread the word, circulating Thomson's *New Guide to Health,* lecturing in public forums on the benefits of the system, prescribing Thomson's compounds, and selling Family Rights to the patented program. Unlike homeopaths, who were trained professionals, Thomsonians preached the gospel of self-help. They rejected the need for medical doctors and medical schools, arguing that people should be allowed to treat themselves. Thomsonianism allowed women, considered to be superior nurturers and caretakers by virtue of their sex, to practice family medical care and encouraged the male head of every American family to "in medicine, as in religion and politics, think and act for himself."[24]

A third sect grew around the theory of hydropathy, which relied on the curative properties of "pure" or mineral water used both externally and internally. Also extolling the benefits of fresh air, sunshine, exercise, and proper diet, this program was particularly popular on the

Mississippi Gulf Coast. There, "watering places," promising social and recreational as well as medicinal advantages, lured many visitors. A variety of resorts offered "valuable mineral springs," which would afford the patron a "remarkable recovery from the extremist cases of debility and sickness."[25]

Indicative of the response of Mississippians to hydropathy were the two sisters who were treated by a Dr. Byrenheidt at his institute in Biloxi. One of these young ladies, Kitty Hamilton, praised the doctor's "delicacy and consideration for female modesty."[26] Her sister, Penelope, lamented the "hours of pain and anguish" that had befallen her under the care of "pillgivers," who had "butchered" her with their "poisonous drugs." Dr. Byrenheidt, she gladly reported, prescribed no drugs, only cold water and exercise.[27] There is little wonder that such a natural, hygienic regimen would be more helpful and popular in treating health complaints than the technique of bleeding or the administration of drugs like mercury!

The "pillgivers" and their "poisonous drugs" of which Miss Hamilton complained were visible in every quarter of the nation throughout the antebellum period, and not just from the medical profession. Family and folk remedies were patented, widely advertised in the vocal and influential *Jacksonian Press*, and peddled in traveling medicine shows. In Mississippi a variety of panaceas and elixirs, the alcoholic content of which often far surpassed any healing virtue, guaranteed to treat everything from "venereal and mercurial diseases" to freckles to cholera to rabies to baldness. One Dr. Rolfe, for example, offered a wide array of medications including Botanical Drops, Asthmatic Pills, Antibilious Pills, and Aromatic Pills for Females. Collectively these promised to cure leprosy, foul and obstinate ulcers, sore legs, pimples, and digestive troubles.[28] Advertisements for Radway's Ready Relief claimed that within twenty minutes the tonic would curtail "violent and excruciating pain" and in a slightly longer time would cure frostbite, mumps, sprains, and kidney disease.[29] Other tonics such as Turkey Opium, Swain's Panacea, and Lee's Original Highly Improved Family Medicines were available to Mississippi citizens.[30] The most confident of these promised "no cure no pay." For those preferring more traditional remedies, a supply of "the best imported Leeches" could be purchased from time to time.[32] This situation not only in Mississippi but throughout the nation prompted the eminent physician and man of letters Oliver Wendell Holmes to remark that if all the *materia medica* were dumped overboard, only the fish would suffer.[33]

For those who carried individualism to the extreme, there were plenty of books and pamphlets on self-medication, including instructions on amputation. The rallying cry for the Thomsonians, "Every man his own physician," was accepted by more than just his followers.[34] The Mississippi press abounded in advice concerning medical treatment and in advertisements for specific medicines and for such items as amputation tools, surgical instruments, and medical books explaining chemistry, surgery, and fractures.[35] The availability of these home remedies, together with the appeal of the sectarians, presented the orthodox physicians with competition stiff enough to prompt them to employ a practice that is today quite controversial. Hardly a newspaper was published that did not include several commercials in which ambitious doctors, often designating hotel or boarding house rooms as their offices, boasted of their credentials and claimed the ability to cure almost any disease. They even assured the public of their willingness to make house calls, especially for female patients.[36]

That bizarre sects, outrageous nostrums, and "do-it-yourself" medical care should abound in antebellum America is not surprising, given the political climate of the times. These were, in fact, merely the medical expression of the Age of Andrew Jackson, the political figure whose personality and image set the tone for the whole period. To most Americans President Jackson was the quintessential self-made man. His devoted following believed that his inauguration in 1829 ushered in a radically new era. Encouraged by his leadership, they rejected the elitism that had characterized the early American Republic, replacing the class distinctions that were prevalent in that society with the kind of social and political equality that bore the name of their hero, Jacksonian Democracy. In the area of politics, this mood led Americans to demand that the rights of the individual be protected against centralized control and corporate power. In the area of health care, this led medical apostates such as Thomson to call on the common man "to throw off the oppressive yoke of priests, lawyers, and physicians and assume his rightful place in a truly democratic society.[37]

The "truly democratic society" of which Thomson spoke was in many ways more imaginary than real by modern standards. Nevertheless, America in the Age of Jackson was an open and mobile social order pervaded with a spirit of democracy. That spirit was symbolized by Jackson and was given substance by a series of state laws that established white manhood suffrage and created an almost completely elective government. Mississippi partook of Jacksonian Democracy to the fullest. After all, the state's citizens revered "The Hero" to the extent that they named the capital for him. During this time the

population grew rapidly, and the production of cotton, the staple crop that formed the basis for the state's economy, expanded greatly. The availability of fertile lands created attractive economic opportunities for the ambitious and the industrious. At the same time Jackson's loudly voiced championship of the common man and his advocacy of individualism gave rise to an attitude that was scornful of institutional restraints. One of those restraints, which represented to many the remnants of elitism and favoritism, was the law that allowed only licensed physicians to practice in the state. In 1836 the several acts that protected a licensed medical profession were declared unconstitutional by the Mississippi High Court of Errors and Appeals.

The laws relating to medical licensure centered around a Board of Medical Censors, which had been established shortly after the state entered the Union to regulate medical practice. In accord with precedents set by other, older states, this Board was empowered to grant licenses to those who could pass an examination and could prove that they possessed both the "usual credentials " and an acceptable reputation. The Board was also charged with publishing the names of licensed physicians so that the public could be forewarned of the qualifications of practitioners.

Within a few years after the first Board was established" others were created to facilitate the licensure process in a state still severely hampered by the problems of internal travel. Moreover, the laws themselves were strengthened "to prevent the empirical practice of physic and surgery" in the state. Doctors were required to record their licenses with circuit clerks, pro visions were made for a grand jury to indict anyone who practiced without a license, and both monetary and prison penalties were prescribed for those who violated the law." And, though certainly qualifications were not high by today's standards, at least some candidates were rejected. Politician Henry Stuart Foote, in his reminiscences of early Mississippi, recalled a comic scene in Natchez in December 1830 when a candidate who had been refused by the Board of Censors "had solaced his chagrin by huge potations of alcoholic fluid.[38]

Another candidate who had been refused by the Board solaced his chagrin in a more aggressive manner. In 1833 a man named Bryant was indicted and convicted in Wilkinson County for practicing medicine without a license. Bryant was an apostle of the popular Thomsonian system. The Board, however, was comprised of orthodox physicians who spurned the various sects and used the licensure laws to discredit them. Unwilling to accept defeat gracefully, Bryant appealed his case to the Mississippi High Court, where he met with complete success three years later. Not only was he personally vindicated, but the entire licensure process was invalidated. The precise legal disposition of the case was based on a technicality regarding the composition of the Board of Censors. But the implications of the decision were replete with the spirit of Jacksonian Democracy, which was inimical to any form of the privileged, closed society that a licensed medical profession represented.

The Bryant case challenged both the procedure and the principle of medical licensure in Mississippi. It focused on the constitutionality of the Board of Censors. In 1832 the state had adopted a new constitution, probably the most highly democratic in the nation at that time. In an effort to forestall the elitism that inhered in public offices that were held in perpetuity, the Bill of Rights of the new constitution demanded that limitations be imposed upon the tenure of all offices. The Board of Medical Censors, however, was made up of seven members who were selected to hold office during "good behavior" and empowered to fill vacancies in their own body. Good behavior, of course, often meant a lifetime appointment, while the power of perpetuity embodied in the replacement provision smacked of a closed class. Thus the nature and composition of the Board were held by the High Court to be incompatible with the principle of rotation in office established by the Constitution of 1832 and espoused by President Jackson himself. Bryant was exonerated, the lower court decision that had convicted him was reversed, and the Board of Medical Censors was disbanded.[40]

As significant as the decision itself were the arguments used in Bryant's defense, for they shed light on the medical mentality of Jacksonian America. The Thomsonian system was, according to Bryant's defense attorney, a "new discovery" in the "art" of healing diseases, a discovery that had been formally patented under the laws of Congress and the United States Constitution. Because of that patent issued by the federal government, Bryant, a legal assign of Thomson, "had full and ample authority to compound and administer the medicines recommended by the owner of the patent. It followed, then, that no state could limit his use of the federally patented system or any medications thereof. The lawyer argued:

> Can a state law forbid the patentee from the United States of a new discovery in constructing a sawmill, from using his discovery in the state unless he shall first qualify himself by an apprenticeship to the old mode of mill-building, and get a license from a board of old fashioned mill-builders, that he is qualified in a theory which he has no desire to practice?[41]

That the identification and treatment of diseases

could be categorized as a theory on which there was no general accord, a theory that could be successfully challenged by a totally incompatible system, clearly indicates the uncertainty and misunderstanding that surrounded medicine in Jacksonian America. The lawyer's comparison of the Board of Censors, who represented the best educated physicians, to "a board of old fashioned millbuilders" reflects the general low regard in which orthodox physicians were held. The 1836 ruling in effect institutionalized prevailing attitudes regarding the state of the art and the state of the profession. The ruling also, with one stroke, moved matters from bad to worse by effectively removing any control over the practice of medicine in Mississippi for nearly half a century. This action left the profession in a state of disarray and medical standards in shambles.

The Bryant decision was, it should be noted, part of a nationwide trend, which, by the eve of the Civil War, had rendered virtually every state in the Union devoid of any effective licensure arrangements." As a result of the hostility of the public towards licensure, medical conditions throughout the nation sank to an all-time low. Practice was open to all comers. The well-known physician Samuel Cartwright, the first president of the Mississippi State Medical Society, observed that, after the dissolution of the Board of Censors, "cobblers left their lasts, blacksmiths their anvils... even grey headed tailors jumped down from the board to become reformers in physic."[43] While he undoubtedly exaggerated a bit, the fact remains that by 1860, Mississippi boasted a physician-population ratio that would have degrees or state medical licenses. Though there are no records that this association ever materialized, active town societies were established in Natchez and Vicksburg.[49] In Natchez, which was the largest and most cosmopolitan city in the state during the antebellum period, the orthodox, organized physicians successfully, pushed the city to circumvent the Bryant decision. After the failure of several legislative attempts to establish new state licensure agencies, Natchez set up its own Board of Censors in 1844 to regulate admission to practice within the city. It is interesting to note that the Natchez Board took pains to avoid a repeat performance of the previous challenge. Botanics such as Thomsonians were specifically exempted from those subject to licensure.[50] Two years after the creation of this board, the Natchez Medical Society called for a statewide convention of physicians to form a state medical society.[51]

The first meeting of the Mississippi State Medical Society, which had about fifty participants enrolled, was held at Mississippi College in Clinton in January 1846. Members there chose officers and discussed several matters, the most important of which was the need to improve the image and the standards of the medical profession.[52] Two months later the society selected delegates to attend a national convention which would address the same issues.

The American Medical Association was formally organized in 1848 and immediately began to work towards regulating and narrowing the profession by establishing criteria to distinguish between the orthodox, trained physician and the empiric or sectarian.[53] But Mississippi's interest in the national organization waned as the tension between the North and the South increased during the next few years. The state medical society did not meet again until 1856, when delegates restated the pledge to take medicine from "various and sundry self-styled doctors, who practiced medicine and sold nostrums and panaceas."[54] However, the apparent lack of dedication in this period of political turmoil- only six are recorded in attendance at this meeting-forestalled effective reform until after the Civil War. Unlike medical societies in other southern states, the Mississippi group was never organized well enough to publish a medical journal.

In fact, neither the state nor the national association achieved a solid institutional base or made any real impact on the profession until the postwar period. The political developments of the 1850s precluded Mississippi's participating in any appreciable manner in activities that transcended sectional boundaries. Still, these rudimentary state and national groups did initiate an eventually successful drive to regulate membership in the profession and to exclude quacks and irregulars from practice. Since politics had made it impossible to accomplish these ends through licensure laws, a possible alternative lay in raising the requirements of medical education.

The AMA from the beginning endorsed educational reform, hoping somewhat naively that medical schools would strengthen their curricula and improve their educational programs voluntarily.[55] In Mississippi Dr. Cartwright addressed the problem of upgrading the profession at the group's initial session. Cartwright denounced the "injury done by imperfectly educated and unqualified young men being admitted by scores to practice."[56]

On another occasion he even went so far as to claim that despite the frightening array of health problems that plagued the Deep South, a "main cause of the great mortality of this valley" was "the direct agency of ignorant and empirical practitioners."[57] Cartwright's concern over the quality of nineteenth-century medical education

was well placed. Added to the problems presented by empiricism, medical sects, and heroic medicine was the inadequacy of training throughout the nation. Many would be physicians obtained their entire education through the traditional method of "reading" medicine and serving several years as apprentices to practitioners. Of those who had more formal training, a few traveled to the European universities, but most enrolled in the short, undemanding, didactic courses offered by American medical colleges. While some of these colleges were associated with respected, established institutions of higher learning, throughout the nineteenth century literally scores of medical schools were founded as private, independent proprietary concerns. Since both the university-affiliated and the commercially-oriented proprietary schools competed for students, neither imposed strict admission standards or graduation requirements.

For young men in Mississippi who aspired to become physicians, several possibilities were open. The availability of medical books and instruments, along with the public nature of lectures in such sectarian practices as Thomsonianism, provided a rudimentary medical education for those who were content to teach themselves. For a more formal education, both university proprietary schools in other states not only accepted but even recruited students from Mississippi. The Ohio Reformed Medical College, for example, frequently advertised in the local newspaper in an attempt to entice students to enroll.[58] Although there were few medical schools in the South until the decade before the war, the Louisville Medical College and the Medical Department of the University of Louisiana, now Tulane, were patronized by Mississippi students, as was Jefferson Medical College in Philadelphia.[59]

Within the state there were a few somewhat feeble attempts to train physicians, but antebellum Mississippi never produced a successful, long-lasting medical school. A number of the academies and colleges that proliferated during that time offered courses in such basic sciences as chemistry, and one even taught special medical training. Opened in the Eagle Hotel in Jackson in 1845, this short-lived school offered medical instruction from James L. C. Thornton, M. D., who also served as Professor of Natural History, Experimental Philosophy, and Chemistry.[60] At one point the governing board of Jefferson College, the oldest college in the state, considered establishing a course of medical instruction, but plans never materialized. During the crisis of the Civil War the state legislature chartered a private medical school, the Southern College of Medicine and Surgery, Inc., to teach the science and practice of medicine and surgery. One corporate member of this enterprise, S. D. V. Hill, later served as president of the state medical association and head of the State Board of Health.[61] A paucity of records makes it impossible to evaluate the success of this endeavor, but apparently its existence was quite brief.

Though neither the state government nor the private sector felt any obligation to educate physicians, there are indications that government officials did feel an obligation to provide for the general well-being of the population. In reality this concern, however admirable and farsighted it may appear on the surface, was intermittent and inadequate, usually arising in response to a particular emergency and lapsing once the emergency subsided. Moreover, there was some controversy over the responsibility and the power of the government to protect the public's health. A disagreement arose in Vicksburg, for example, when the mayor and common council ordered a local hotel to be closed after a case of smallpox was reported there. Protesting this government interference in private business, merchants and prominent lawyers argued that the city did not have the authority to take such steps.[62] Only after a major yellow fever outbreak in 1853 proved the necessity for some control did the legislature settle that question once and for all. Thereafter, Mississippi towns were specifically granted the power to establish regulations to aid in the prevention of yellow fever, smallpox, and other communicable diseases.[63]

The proper regulations to control communicable diseases were debatable, though, for no one understood the causes. Even so, authorities came surprisingly close with their attempts at quarantine and sanitation. The primary target of the government's concern was Natchez, which during the antebellum period was not only the most populous city in the state but also the source of peculiar health problems because the river traffic brought a constant influx of strangers. Only a year after the state entered the Union, the legislature created a Board of Health for Natchez and then ten years later provided a special public Health officer for the river town.[64] But neither of these agencies operated with vigor or efficiency. The legislature also attempted to prevent "the fatal calamities of contagious diseases" by forbidding "foreigners of infamous character" to enter the state by land or boat.[65] The Natchez Charity Hospital, originally founded to isolate sick and indigent strangers, especially boatmen, was later designated a state hospital and was allotted periodic appropriations from the state as well as from the county and city.[66]

These gestures of government responsibility were the exception rather than the rule. There was never in the antebellum period either a sustained public health move-

ment or an official and permanent public health agency in the state, nor could there be. Until both officials and physicians began to grasp the origins of the disease they sought to control, there was little hope that effective measures could be taken.

The first disease to be understood and subjected to effective measures was the dreaded smallpox, which had arrived on this continent with the first Europeans and had proved to be as effective as gunpowder in decimating the native Indian tribes, including those of the Mississippi River Valley.[67] There had been throughout the colonial period a recognition that immunity to the disease could be induced by a process known as variolation, which exposed a patient to live smallpox virus. The discovery of the Jenner cowpox vaccine in the late eighteenth century made artificial immunity a much safer process and marked a major step in the progress of medicine and public health. In 1846 Mississippi became the first state in the South to establish a vaccine depot, which was charged with procuring, maintaining, and distributing the vaccine throughout the state.[68] In addition to this important development, other medical findings and innovations paved the way for the decisive transformation that took place in medical practice after the war. But for the most part these innovations were still in the experimental stages in the antebellum era, understood by few and employed by fewer. The state of the art was not noteworthy when the war broke out. This was especially true in the South. There, an increasing alienation from the mainstream of American development arose as the issues of slavery and states rights became ever more divisive. Self-imposed isolation severely limited intellectual stimulation and left the South cut off from the scientific knowledge accumulating in the North. It also created in the region a siege mentality that tended to retard scientific inquiry and to reject freethinking for the sake of orthodoxy. The stultifying effect of this orthodoxy, both in religion and in politics, can be readily seen in the career of Samuel Cartwright, who became the Old South's leading advocate of what has been called "states-rights medicine."[69]

Cartwright, a student of Benjamin Rush who became a successful Natchez practitioner and later a prolific writer, was also an active reformer and organizer in the field of medicine. Like many other physicians he was quite involved in local politics and could, according to the *Vicksburg Register,* compose "a dissertation on Cayenne Pepper or Democracy with equal facility."[70] But as the tension between the North and the South increased, both his politics and his medicine acquired sectional overtones. He insisted for instance, that more medical schools should be established in the South so that southern physicians could train southern students to deal with the South's peculiar problems, especially the Negro." Eventually the sectional overtones overtook the scientific mind.

Cartwright came to accept the theory of polygenism espoused by Dr. Josiah Nott of Mobile, another prominent southern physician who applied his medical expertise in defense of slavery. These two held that the different races of mankind had separate origins and that they should therefore be treated as separate species. Skull formation, Cartwright argued, confirmed that point. Moreover, he continued, the dark pigmentation of the Negro's skin was not confined to the skin but in fact pervaded "to a certain extent even the brain itself with a shade of darkness." Through complicated anatomical tables Cartwright proved "that the Negro was mentally inferior, given by nature to do menial tasks under the hot southern sun without harm." He went on to identify several diseases that had believed to be unique to the Negro, diseases that caused blacks to wander and prevented them from overworking.[72] Thus for medical reasons, Cartwright concluded, liberty, the morally elevating prize of white civilization, was "not only unsuitable to the Negro race, but actually poisonous to its happiness." For his views and accomplishments the doctor was appointed as Professor of the Diseases of the Negro in the Medical Department of the University of Louisiana.[73]

While some of his contemporaries considered Cartwright's ideas to be eccentric, by 1860 few in the white South quarreled with his intentions. The adverse effect of this line of thought on the progress of biological and medical science can be seen in a number of incidents involving scientists with unorthodox tendencies. And yet, as deleterious as this southern dogmatism was, equally negative in its impact was the idealization of the life style represented by the plantation system. Nowhere in nineteenth century America was either the prestige or the income of the medical profession sufficiently high to attract and keep the nation's most capable young men. In the South this problem was intensified by the fact that romanticization of the Southern Way of Life, which was embodied in the plantation slave system, enticed educated, promising young doctors to use their profession not as an end in itself but as a means to an end. Subscribing to the "cult of the gentleman-planter," many practicing physicians viewed farming as the "noblest occupation" in which man could engage."[74] They often raised cotton on the side, with the aspiration of purchasing more land and slaves to secure for themselves the wealth and status that were not afforded to the lowly country doctor. In Missis-

sippi physician-planters were counted among the largest slaveholders in the state, in fact in the whole South, on the eve of the Civil War. Dr. Stephen Duncan, for example, owned 717 slaves in 1860. Two other physician-planters, Drs. William Mercer and John C. Jenkins, possessed 452 and 424, respectively.[75]

The physician-planter was not long for this world in 1860, for the slave system that supported him was doomed to extinction. As had so often occurred before, factors completely beyond the pale of medicine exerted a tremendous impact on medicine. As if to illustrate this very fact, in 1859 three hundred southern medical students who were studying in Philadelphia abruptly curtailed their education and left en masse to protest the North's sympathetic reaction to John Brown's aborted slave uprising.[76] The guns of Fort Sumter sparked a decisive alteration not only in the course of American history but also in the course of American medicine. Battlefield conditions and the widespread existence of disease, malnutrition, and deprivation created medical problems of truly staggering proportions. The suffering experienced during the four-year ordeal of the nation intensified the need for improved medical knowledge, procedures, and resources throughout the nation. Momentous strides in scientific medicine and public health were made as the wounds within the nation began to heal. The postwar period marked the emergence of modern America and also the emergence of modern medicine. Buried, albeit slowly, with the Old South were the quacks, the sectarians, the heroic tactics, and the states-rights posture that had been the hallmarks of medicine in antebellum Mississippi.

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An Approach to Reducing Infant Mortality Rate Through the Utilization of Lay Home Visitors

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INTRODUCTION

Despite efforts to lower the infant mortality rate (IMR) on the part of the Mississippi health care system and related organizations, Mississippi continues to be burdened by one of the highest rates in our nation. Through a medical triage system of primary, secondary and tertiary care centers combined with a rapid transport system, high-risk, critically ill newborns receive state of the art medical care in our state. Pregnant women have been targeted with information on the necessity of early and continuous prenatal care. Why then have we failed to observe a more dramatic fall in our IMR? The hypothesis we wish to explore in this article is that the major determinants for infant mortality in the State of Mississippi are found in socioeconomic factors. When conditions associated with these factors are addressed by community members themselves, a beneficial change can be made.

In 1990 we obtained a five year Healthy Tomorrows grant through the American Academy of Pediatrics to address the major health problems among children in Sharkey County. For decades we have been confronted with infants and children at high risk environmentally. The 1987-1991 average infant mortality rate in Sharkey County of 16.3 was the visible presence of a much larger body of ill health with outcomes in the form of failure to thrive, developmental delays, behavioral problems and later school failure. In order to address these problems at their source in the community, we mobilized community people and instituted a Lay Home Visitor program.

LAY HOME VISITOR CONCEPT

The Lay Home Visitor program is not a new concept. It was pioneered in the 1970's by Dr. C. Henry Kemp from the University of Colorado.[1] He used a broad network of community lay home visitors to identify children at risk for abuse. There was the near elimination of abuse among the children and families monitored by these home visitors. In the late eighties, Dr. Calvin C. J. Sia developed a medical home model in the state of Hawaii.[2] A medical home provided each child access not only to medical services but a coordinated way of accessing the services they needed from the various local, state and federal agencies. A vital component of the medical home were the community lay home visitors who linked the medical home to children and families who were at environmental risk.

In the traditional practice of medicine, physicians see those families who are motivated to come to their offices for care. In most cases, these families are interested in maintaining their health and are a pleasure to care for. Frustrating, however, are those high risk patients who need the expertise most but are least compli-

ant in following instructions and keeping appointments. In many instances these patients are seen in hospital emergency rooms rather than the office. Their medical problems are often a small component of a much larger psychosocial dysfunction that regular office personnel are not equipped to handle. It is in this arena that the outreach of the lay home visitor becomes critical to the delivery of effective and culturally relevant health services.[3]

HOME VISITOR SYSTEM

Cary Christian Center was founded over 25 years ago to address the health needs of underserved, impoverished Sharkey county in the delta. From its inception the medical clinic provided transportation services for isolated families. The clinic services targeted high risk pregnant women, infants, children and adolescents. Because of the need for health education, transportation was provided for prenatal, infant stimulation and child rearing classes. In a county where the nonwhite population was 65% and 60% of the population lived below the poverty level, the IMR did not go below 16.3. It was while wrestling with this problem that we began exploring the use of home visitors. Funding by the American Academy of Pediatrics made this a possibility.

The home visitor provides a strong link between the clinic and the at-risk patient. As long-term community residents, they know the community and have the trust of their neighbors. A minimum of education is needed since they are already mothers, come from stable homes and have raised or are successfully raising their own children. Continuing education based on their work experiences, however, is extremely important and occurs on a regular ongoing basis.[4] This education is provided by the health educator, physicians or other experts as needed. It serves as a means of maintaining both quality of practice and cohesiveness among the group. It is important to note that the organizational umbrella under which the home visitors function is separate from the medical clinic but functions in close collaboration. The health educator supervising the home visitors is knowledgeable in preventive health and able to bring together the medical and preventive health aspects so necessary in patient care. The home visitors' contact with the medical clinic revolves around patient referral and follow-up. Meetings are held with the physicians at least monthly. Each home visitor has a telephone and 24 hour coverage is maintained for patients in need. In the preventive arena the home visitors assist the health educator in teaching prenatal, infant stimulation and child rearing educational classes. This further defines them as health resources in their communities where they participate in ongoing preventive health education, health promotion, early identification of risk factors and the referral of those individuals who need medical attention.

ROLE OF THE LAY HOME VISITOR

Examining children in the medical office provides very little knowledge or insight into the environmental and psychosocial constraints under which those children live. The home visitor provides that insight and becomes the informational bridge between the office and the home. Because they come from the community and have the community's trust, they have access into homes as well as a network of contacts informing them of women who are pregnant, those in need of care and those returning home with newborns. As a result, approximately 80% of all newborns in Sharkey County are home visited within the first two days of discharge and all are seen within the first week. Being mothers with the added benefit of special training, the home visitors can identify young mothers in need of support and nurturing, and those infants not gaining weight or who are acting abnormally. The vast majority of those the home visitors call on do not need a clinic referral but rather a knowledgeable, caring presence. Home visits continue to be made on infants and children during the first three years of life.

The role of the home visitor is not making a diagnosis but rather of education, nurturing and the identification of infants, children, mothers and pregnant women at risk. The home visitors are able to recognize bonding risk factors which potentially may lead to abuse or failure to thrive with resulting abnormal physical, emotional and mental development (table 1). Home visitors perform another important function by serving as a human services coordinator for their patients. Home visitors help their clients to understand and utilize the multiple service agencies each with its own limited offer of services.

Upon referral to the medical clinic the home visitor personally provides transportation to the clinic in order to guarantee the provision of care. This type of intervention and the close collaborative relationship with the physician is felt to be very important. The home visitor role necessitates certain important attributes in order for them to function effectively. As a consequence people personally known by the Cary Christian Center staff with certain basic characteristics (table 2) have been chosen.

Table 1. – Observations to be Made at Postpartum and Pediatric Checkups[1]

1. Does the mother have fun with the baby?
2. Does the mother establish eye contact (direct in face position) with the baby?
3. How does mother talk to her baby? Is everything she expresses a demand?
4. Are most of her verbalizations about the child negative?
5. Does she remain disappointed over the child's sex?
6. What is the child's name? When did the parents name the baby?
7. What are the mother's expectations for the child's development?
8. Is the mother bothered by the infant's crying?
9. Does she ignore the baby's demands to be fed?
10. What is her reaction to changing diapers?
11. When the baby cries, does she or can she comfort him?
12. What kind of support is the mother receiving?
13. Are there sibling rivalry problems?
14. Is the father present in the home?
15. Does the mother maintain control of the child in the presence of the home visitor or does she relinquish all care (undressing, holding, etc.) ?
16. Does the mother make nonexistent claims about the child?
17. Does the mother make emergency calls for very small things?
18. Are the home physical, sanitary, and child safety features acceptable?
19. Does the mother exhibit interest in the physical and developmental assessment during the visit by the home visitor?

RESULTS

The IMR is a gross parameter for tracking the effects of the lay home visitor activities but it is a statistic compiled yearly by the State Board of Health. Since evaluation funds were not available for more extensive documentation of the lay home visitor activities, we used the infant mortality rate of Washington County which is also in the delta and immediately to the north of Sharkey County as our control. Both counties are comparable in their social and economic parameters except for the fact that Washington County is more populous.

The nonwhite IMR is comparable from 1987-1991 in both counties (table 3). Because of so few births, the white IMR in Sharkey county is unreliable.

Table 2. - Lay Home Visitor Profile

1. A mother with a husband who has raised or is successfully raising her children.
2. A member of a community church who is strongly committed to helping people and willing to commit evenings and weekends to doing so.
3. A high school graduate with patience, persistence, initiative, flexibility, empathy and self-assurance.

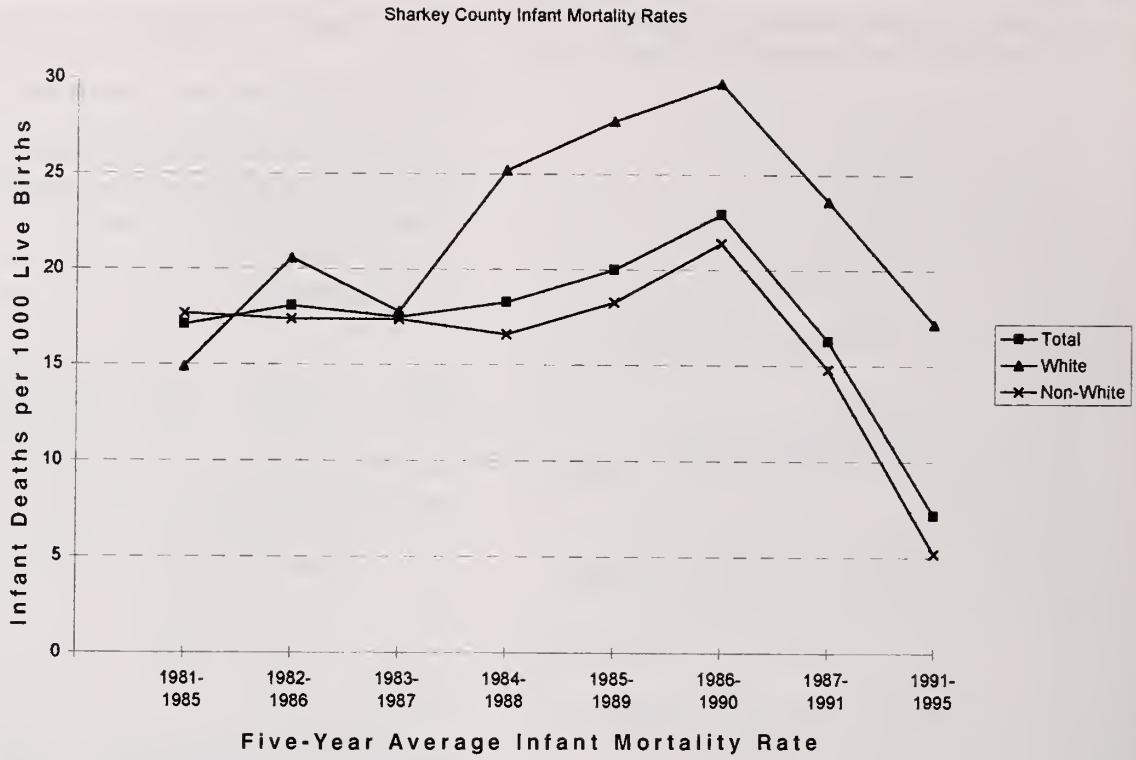
County	Year	Total	White	Nonwhite
Sharkey	1987-1991	16.3	23.6	14.8
Washington	1991-1995	7.2	17.2	5.2
	1987-1991	11.6	5.7	14.0
	1991-1995	11.7	4.2	14.2

Table 3

The drop in nonwhite IMR in Sharkey County coincided with the introduction of the lay home visitors. There were no other changes occurring in the county during this time in the form of the unemployment rate, improved housing, environmental conditions or economics. We looked at the infant deaths in Sharkey County from 1981 through 1990 which totaled 34 deaths. Prematurity accounted for nineteen of these deaths and eight could be attributed to preventable causes in the form of pneumonia, gastroenteritis, shigellosis, etc. For each of these five year segments from 1981 to 1991 there were 9.5 deaths due to prematurity and 4 deaths due to preventable causes. During the five-year period reflecting the efforts of the lay home visitors, there was a 50% decrease in IMR for a total of 5 deaths(Chart 1). Three of these deaths were due to prematurity with 1 possible preventive death due to a PDA at one month of age.

(Continued next page)

Chart 1.



Because of the limited population (6,875) the total number of births in Sharkey County from 1991 through 1995 was 694 with 5 deaths compared to the larger Washington County population (70,411) with 6,432 births and 75 deaths. The small birth numbers in Sharkey County make it difficult to produce statistically convincing data and yet we have seen a marked improvement in the health of our population with fewer infant deaths and premature newborns since the introduction of the lay home visitor program.

DISCUSSION

Medicine as an institution has fallen into the trap of "medicalizing" our socioeconomic problems.[5,6,7] The disease states we encounter such as eclampsia, premature births, growth and developmental delays, battered children and STDs are often in reality the medical tip of a large iceberg composed of families and individuals living in substandard housing with poor sanitation. Lacking both employment and education, they often live without a caring social support network. To treat the medical diseases emanating from this environmental milieu is necessary but does nothing to address their root causes.[8] As a consequence, we find ourselves treating the same diseases in the same individuals over and over again. We experience in our offices what studies overwhelmingly demonstrate — that access to quality medical care is limited in its effect on health.[9,10,11] A major determinant for health resides within individuals and their communities and not in our medical offices.[12]

Studies at the Albert Schweitzer Hospital in Haiti dramatically demonstrate that thousands of patients can be cared for with minimal benefit to the health of communities surrounding the hospital and little change in their health statistics.[13] When a program was initiated utilizing members from communities trained as lay health workers, there was a dramatic improvement in both the health of the community and health statistics. These community health workers taught community members the causes and prevention of disease. They treated more common diseases such as diarrhea and parasites. These health workers related closely with the hospital and were trained by their personnel. As health needs arose in their communities, there was a vehicle for immediate transfer of this information to the hospital which was then able to equip the health workers to respond in a quality manner to these new problems.

The experiences at Cary Christian Center are similar to those in Haiti. For 20 years our clinic program targeted environmentally high-risk patients in Sharkey County. In addition to medical services, we provided preventive health educational classes. A transportation system provided access to medical as well as educational services. Incentives were given to pregnant women to attend prenatal classes. In spite of this, and the fact that thousands of patients were treated and educated, the

infant mortality rate did not fall significantly below that of surrounding counties. With the introduction of the community lay home visitor program, there was a drop in the infant mortality rate. The incidence of premature infant births and post neonatal deaths due to preventable causes were markedly reduced. Three home visitors working half-time made over 3000 visits in 1995. Each home visitor is responsible for a minimum of 40 families. Not measured but of equal significance is the 1) satisfaction of mothers with a caring supportive presence, 2) the early recognition of potential abuse with prompt intervention, and 3) the positive parenting that has been occurring because of education provided by these home visitors. So often the things that really count can't be counted.[14]

RECOMMENDATIONS

Since the population in Sharkey County does not make a statistically valid study possible, we would recommend that a study be initiated in a larger county and with a broader range of parameters for evaluation. If such a study validates our experience in Sharkey County, home visitors should be placed in each county and in every community with a population of over 10,000. We believe these communities would experience a dramatic health benefit at a minimal financial cost. This type of community based care will become a necessity as we attempt to deliver more effective care to environmentally at-risk patients without escalating our health care expenditures.[15]

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We wish to thank Dr. Philip Rhodes, Chief of the Division of Neonatalogy, The University Medical Center for his review of this article and helpful comments. A special note of thanks goes to Irma Johnson, Barbara Williams and Hattie Lewis, the home visitors who have made a difference in the lives of so many individuals in Sharkey County.

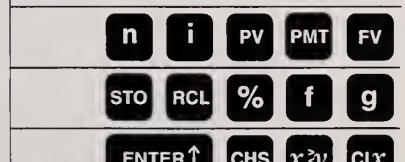
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H. Vann Craig, M.D.

The President's Page

The Federation of Medicine Study

The AMA has had an ongoing Study of the Federation of Medicine for the past several years in an effort to improve the functions, processes and relationships of our Federation. It is both a formidable and admirable undertaking.

The study has already resulted in changes in the composition of the AMA House of Delegates. Previously the House was composed of delegates from each state medical association elected on a proportional basis and national specialty societies that met criteria to be allotted one delegate each. One of the quarrels that my specialty society had with the AMA when it chose not to participate in the House of Delegates was that it had several thousand members but only one vote. The Study of the Federation resulted in the House recognizing that since many physicians belong to national specialty societies in addition to their state medical association they should be represented by those organizations. Each member of the AMA is now asked annually to indicate the specialty society they want to represent them in the House of Delegates. Our specialty societies increase their votes proportionally in the House based on this vote.

When you receive your ballot, vote for the specialty society you want to represent you in the AMA House of Delegates. Also, urge your national specialty society to support the Federation of Medicine Study effort. It can only result in a better "House of Medicine" for our profession.



Editorial

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Mississippi Medicine in the "Dark Ages"

Once in a while a written piece comes to our attention that just cries out to be published in the *Journal MSMA*. Such an article is found in this month's issue... "Medicine in Antebellum Mississippi" by Lucie Robertson Bridgeforth, a history professor at Northwest Jr. College in Senatobia, Mississippi, Dr. Bridgeforth wrote and first published this article in May 1984 in *The Journal of Mississippi History*. Her work concentrates on the forces of change that molded the face of medicine in the first forty years of Mississippi history, the period immediately prior to the Civil War. Economically it was the "Golden Age of the Old South" when fortunes grew lush right along side of "King Cotton."

In contrast to this, the American South was in the political "Age of the Common Man" owing largely to the burgeoning influence of Jacksonian Democracy.

But as Dr. Bridgeforth so well said, those years were the "Dark Ages of American Medicine." As you read this article you'll quickly appreciate why.

The desperate need for medical care in the epidemic-ridden Antebellum period, coupled with the scientific limitations of those times and the reigning political philosophy of the "self-made man" all served to encourage the development of medical quackery.

Bridgeforth writes "one of these... institutional restraints ...which represented to many the remnants of Elitism and Favoritism, was the law that allowed only licensed physicians to practice in the state. In 1836 the several acts that protected a licensed medical profession were declared unconstitutional by the Mississippi High Court of Errors and Appeals."

These rulings removed all restraints over medical practice in Mississippi for several decades and "left the profession in a disarray and medical standards in shambles" as literally anyone could then declare himself a physician and freely practice "the medical profession" in Mississippi. As a result, all physicians were held in contempt by a population who desperately needed care but mistrusted and despised those who practiced it.

Sound familiar? To again quote Dr. Bridgeforth, "Even in today's antiseptic, highly technical world, medicine cannot be extricated from the political, social, and economic milieu in which it exists."

And what saved us back then? None other than the fledgling establishment of organized medicine in our state ... a group of concerned and competent physicians saw a need and met it.

The medical profession was not made respectable again until our predecessors formed the "Mississippi State Medical Society" which first met at Mississippi College in Clinton in 1846. Fifty doctors attended, they chose officers and "discussed several matters, the most important of which was the need to improve the image and standards of the medical profession." The American Medical Association was not formally organized until two years later in 1848.

Take a break tonight from reading your usual medical journals or John Grisham novels and read this article. It is a fascinating look at our profession's difficult adolescence. You will be intrigued and inspired and once again reminded that the old adage... "the more things change, the more they stay the same" still rings true.

-Dwalia S. South
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Have You Returned Your MSMA Member Survey?

You have received in the mail a survey and letter asking if you as a Mississippi physician, would be willing to invest in a physician owned and physician operated health insurance company. This obviously needs some explanation. This article is an attempt to explain how we got to this stage.

I was uninvolved in organized medicine until I witnessed how closely our President and his wife came to totally wrecking our profession in 1993. I decided to get personally involved and see if I could make a difference.

I have learned a number of things. As a board member of our state-wide network (Mississippi Physicians Care Network-MPCN) I have discovered many of the limitations we have as physicians trying to respond to managed care. I have seen that insurance companies, other health plans and HMO's have a lot fewer restrictions. As physicians we are very limited in what we can discuss in organized meetings. As stockholders and participants in a health insurance company we would have much more flexibility.

A year ago the board of MPCN created a committee to look at the future of our network. I am on that committee. After carefully studying many options it basically boiled down to two. (1) Become the premier statewide network of physicians and health facilities and contract with HMO's and other payors; (2) Create our own "insurance company" to utilize our network.

An insurance company of our own could set a standard for managed care in the state and how medicine is practiced. We could also offer such products as "Medical Savings Accounts," a concept that many of us think could preserve the doctor-patient control of patient care. HMO's will not do that. They want control for profits and stock dividends.

Our own insurance company will require some personal sacrifice to be financially competitive. But wouldn't you rather give a discount to your own company rather than a company on the New York Stock Exchange? Especially if it helps maintain patient choice and physician-patient control of health care decisions? If we do this right it could set the agenda for medical care in this state for generations.

Many people have asked me, "Didn't we do this back in '87 and loose a bunch of money? What happened to that? You mean you want me to do this again?"

Mississippi Physicians Insurance Company (MPIC) was formed then to be on the ground floor of potential HMO development in this state.

Many of us put up $2,000.00 to buy stock. This timing proved to be premature for the effort. Anyone who wanted out had stock bought back for about $950.00. This was a total loss of about $1,050.00. This is not a "bunch of money" to any of us.

If you kept your stock, as about seven hundred of us did, it is now worth about $2,500.00. The same amount of your stock and membership application fee ($500) in 1987. So you have lost basically no money.

So what has happened to MPIC? It is functioning as a Worker's Compensation Company and doing fairly well. That experience was a minimal-to-no loss venture for those involved.

Timing is NOT premature at this point to respond to a HMO invasion into Mississippi. An insurance company owned by physicians could now play an important role.

The Mississippi State Medical Association has actually been quite successful in past responses to threats to our profession. MACM (Medical Assurance Company of Mississippi) has been very important in assuring malpractice coverage to us at reasonable rates. MPIC (Mississippi Physicians Insurance Company) was created prematurely, but is functioning well. MPCN (Mississippi Physicians Care Network) is up and running with over 100,000 lives covered. The record is not bad. If you actually take the time to look, you find significant success.

Lets get back to the present idea of a health insurance company. One option would be to further capitalize MPIC.

After looking at this we decided it would be easier to create a new company.

Capitalization to assure success is the task before us. If 2,000 physicians would contribute $5 per day for 10 years, we would create capital of $30 million. That would be $15,000 for each 2,000 physicians financed over ten years if necessary. That is very little to risk to be able to possibly influence the future of our profession. The timing is right at this point. As HMO's become established in our state, there will be fewer and fewer people to which this concept can be marketed. NOW is the time.

The survey is only an attempt to see if enough physicians have the will to seize the moment and help our profession. It is not financially binding. If enough physicians are willing, we will move forward. If not, we will loose an opportunity forever.

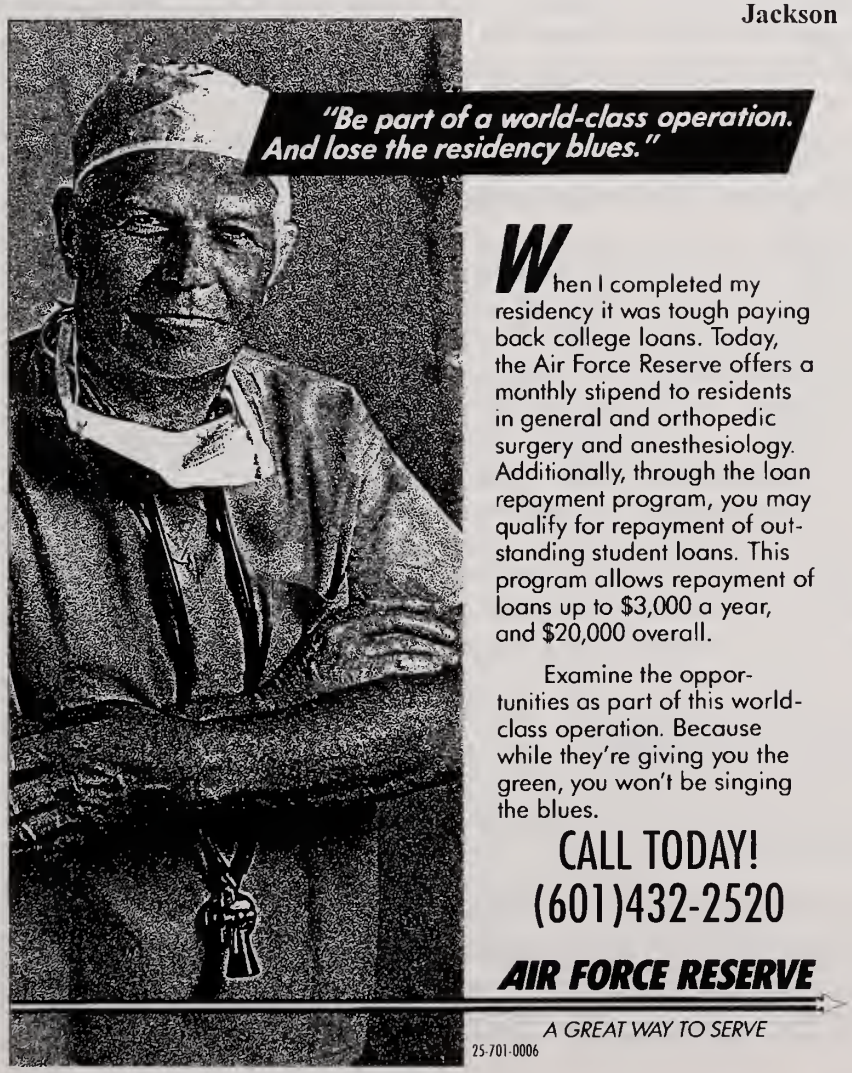
This concept is moving forward in South Dakota, Washington, Louisiana, California, Oklahoma and Texas. It can work here. Please join us in attempting to influence the future of our profession. The insurance company will probably end up a financial success as well. Many insurance companies do.

All the details are simply not worked out yet, so they can not be given to you at this stage. I encourage you to mark the $15,000 or more category on the survey form and then get involved and help create the details. As a stock holder you will be able to do this.

Fill the survey out today and send it in. If you have misplaced it call MSMA and get another one.

Lets become "pro-active" and create a better environment for our profession and the patients we serve. If an overwhelming number of MSMA members respond positively to the survey there will be a special session of the MSMA House of Delegates. Plan to be there!

J. Patrick Barrett, M.D.
Jackson



Atrial Fibrillation Quality Improvement

The Foundation for Medical Care is one of nine Quality Improvement Organizations from states in an area commonly called the stroke belt working to prevent stroke in Medicare beneficiaries with atrial fibrillation (AF). The QIOs are endorsing the use of the International Normalized Ratio (INR) to measure prothrombin time (PT) for patients on warfarin. Recommendations are that patients receive prothrombin times every four to six weeks and that patients and physicians be familiar with target INR levels of prothrombin time to achieve safe and effective anticoagulation required to prevent stroke.

The nine-state Medicare coalition has prepared a consensus statement which was presented in August at the Fourth National Scientific Sessions of the Consortium for Southeastern Hypertension Control held in Orlando, FL. William Golden, M. D., principal clinical coordinator for the Arkansas Foundation for Medical Care, presented the consensus statement in a session titled "Medicare Public Education: Stroke Belt Initiative."

At the Fourth American College of Chest Physicians Consensus Conference of Antithrombotic Therapy under the joint sponsorship of the National Heart, Lung and Blood Institutes in 1995, it was announced again that prothrombin time ratio is no longer a safe or adequate measurement for monitoring warfarin anticoagulant therapy. In conjunction with the World Health Organization, the American College of Chest Physicians recommends worldwide use of the International Normalized Ratio. The INR represents a standardized value regardless of which PT system or thromboplastin source the laboratory uses to test the sample.

Long-term anticoagulation therapy is used widely in the United States for diseases of the cardiovascular system ranging from atrial fibrillation and deep vein thrombosis, with or without a pulmonary embolism, to abnormalities of cardiac structure and function. It is estimated that half a million Americans are undergoing anticoagulant therapy. The benefits and risks associated with anticoagulation are often guided by the patient's response to varying doses of medication. For this reason, careful monitoring of the extent of anticoagulation is necessary.

AF, seen in up to 9 percent of elderly people, can cause blood clots that travel to the brain and cause a stroke. In fact, AF causes 15 percent of all strokes in this country. Patients with AF have a five-fold greater risk of stroke than patients without AF. Stroke is a common affliction of Medicare beneficiaries and the third leading cause of death in the United States. Stroke occurs at a rate of one per minute and is the leading cause of major disability. Stroke results in more than 500,000 hospitalizations, 150,000 deaths and 30 billion dollars in costs each year (Heart and Stroke Facts, Statistical Supplement, 1996).

According to the study, "Risk Factors for Stroke and Efficacy of Antithrombotic Therapy in Atrial Fibrillation" (Archives of Internal Medicine, 1994, Vol. 154), the use of the anticoagulant drug, warfarin, reduced the annual rate of stroke from 5 to 1.6 percent among AF patients. Warfarin, however, requires careful monitoring by both the physician and the patient. Effective use of warfarin to prevent strokes requires titration to achieve an INR level between 2.0 and 3.0. This range offers enough anticoagulation to prevent stroke, but does not over anticoagulate patients and put them at risk for bleeding complications.

The Foundation, along with the other participating QIOs, is currently involved in a public awareness campaign targeting Medicare beneficia-

ries called 'Making Advances in the Prevention of Stroke' (MAPS). The program also includes a clinical component to encourage providers to focus on improving patient education for a high-risk patient group, specifically patients with AF. A total of 44 Mississippi hospitals are participating in this phase of the program.

Funding for the Health Care Quality Improvement Program and MAPS is provided by the Health Care Financing Administration.

Principal Clinical Coordinators from the QIOs endorsed the project in their states and participated in developing the consensus statement. Other states participating include Arkansas, which is serving as project leader, Alabama, Florida, Georgia, Louisiana, North Carolina, South Carolina, and Oklahoma.

Information is available about stroke, AF and INRs in the patient booklet, "Follow Your Heart." The information, available from the Foundation for Medical Care, can be obtained by calling 1-800-844-0600.

"We are pleased to be participating in this important effort," commented Dr. James S. McIlwain, principal clinical coordinator and president of the Mississippi QIO. "It is unfortunate that the oldest patients who would derive the greatest benefits from warfarin appear to have the lowest rate of warfarin usage, especially in the south. We hope this project will increase the number of beneficiaries with AF who are treated with warfarin and encourage health care providers to use INRs to monitor warfarin usage. We will be happy to share any of the information we have available on the MAPS project."

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-James S. McIlwain, Jr.

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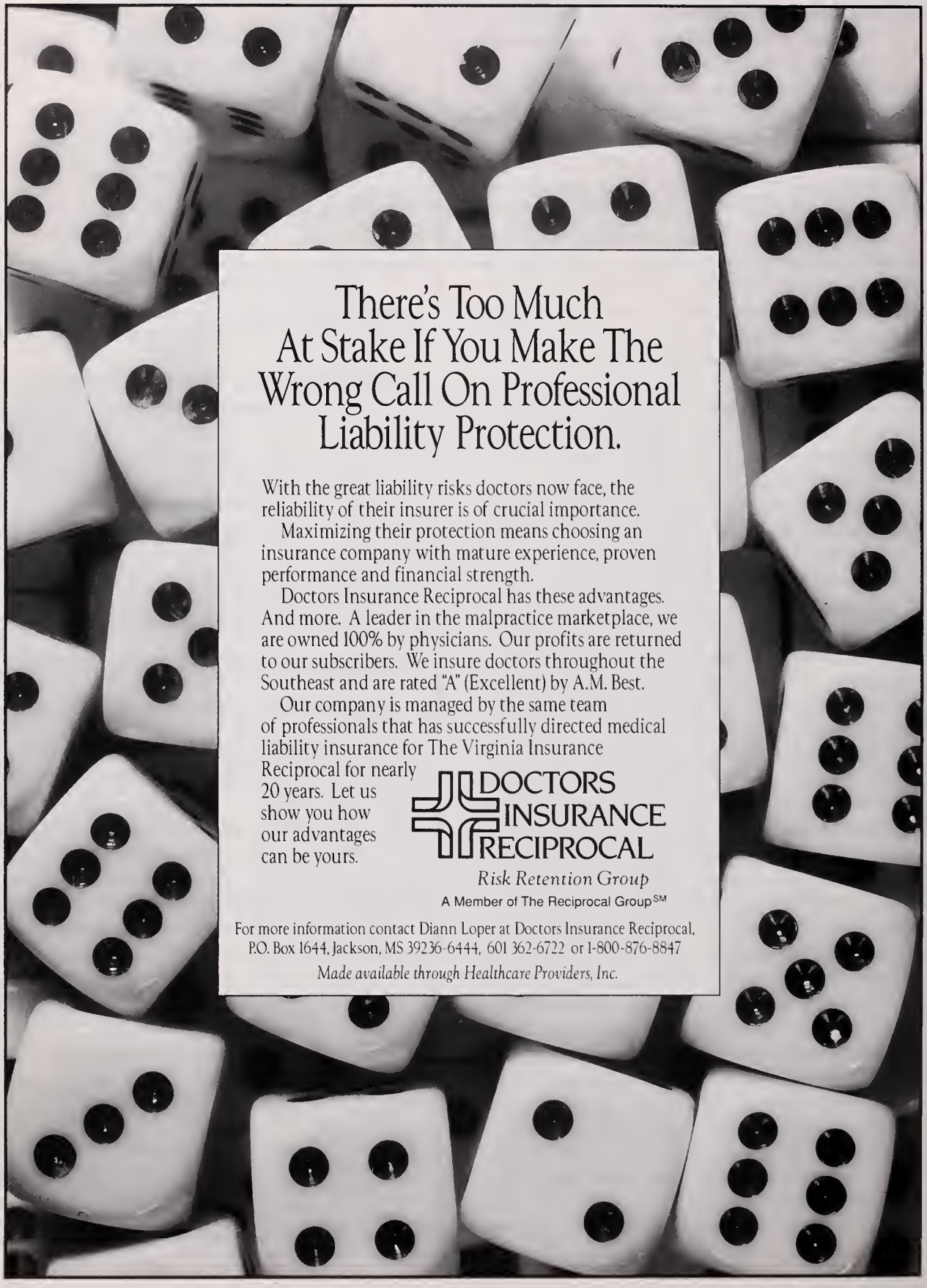
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CRAFTON, EUGENE M., Oxford. Born Brownsville, TN, March 21, 1965; MD University of Tennessee School of Medicine, Memphis, TN, 1992; internal medicine residency, University of South Alabama Medical Center, Mobile, AL, 1992-95; gastroenterology fellowship, University of Arkansas Medical Center, Little Rock, AR., 1995-97; elected by North MS Medical Society.

CRAIG, MARK H., Tupelo. Born Jackson, MS, February 25, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; surgery residency, University Medical Center, Jackson, MS, 1990-95; plastic surgery residency, Medical College of Georgia, Augusta, GA, 1995-97; elected by Northeast MS Medical Society.

CRAWFORD, STEPHEN C., Jackson. Born Carrollton, GA, August 7, 1950; MD Baylor College of Medicine, Houston, TX, 1981; diagnostic radiology residency, University of Iowa Medical Center, Iowa City, IA, 1983-87; neuroradiology fellowship, University of Utah Medical Center, Salt Lake City, UT, 1987-89; elected by Central Medical Society.

ESTES, TIMOTHY D., Jackson. Born Memphis, TN, March 14, 1953; MD University of Tennessee College of Medicine, Memphis, TN, 1980; family practice residency, Methodist Hospital, Memphis, TN, 1980-82; elected by Central Medical Society.

FARMER, CLARANCE S., II, Tupelo. Born Memphis, TN, August 28, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1988; urology residency, University of Mississippi Medical Center, Jackson, MS, 1988-93; elected by Northeast MS Medical Society.

FOSMIRE, HELEN, Gulfport. Born Coatesville, PA, December 21, 1954; MD Oregon Health Science University Medical School, Portland, OR, 1981; one year surgery internship, University of Arizona Medical Center, Tucson, AZ; radiation oncology residency, Same, 1982-85; elected by Coast Counties Medical Society.

FRYE, GEORGE RUSSELL, Meridian. Born Meridian, MS, June 27, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1988; one year internship, Baptist Medical Centers, Birmingham, AL; radiology residency, University of Tennessee Medical Center, Knoxville, TN, 1989-93; elected by East MS Medical Society.

FURNISS, JAN L., Starkville. Born Clarksdale, MS, March 4, 1958; MD University of Mississippi School of Medicine, Jackson, MS, 1983; ob-gyn residency, University of Louisville School of Medicine, Louisville, KY, 1983-87; elected by Prairie Medical Society.

GILMORE, JAMES C., Oxford. Born Houston, TX, June 9, 1953; MD University of Mississippi School of Medicine, Jackson, MS, 1980; interned one year and surgery residency, Mayo Graduate School, Rochester, MN, 1980-85; cardiac & thoracic surgery residency, Ochsner Medical Founda-

tion, New Orleans, LA, 1985-87; elected by North MS Medical Society.

HAJJAR, AMANDA A., Meridian. Born Tuscaloosa, AL, June 13, 1964; MD University of Alabama School of Medicine, Birmingham, AL, 1990; internal medicine residency University of Florida, Gainesville FL, 1990 - 92, and University of Texas Southwestern Programs, Dallas, TX, 1992-93; elected by East MS Medical Society.

HAYS, J CLAY, JR., Jackson. Born Rochester, MN, May 14, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, Mayo Graduate School of Medicine, Rochester, MN, 91-94; cardiology fellowship, University Medical Center, Jackson, MS, 1994-97; elected by Central Medical Society.

HOLBROOK, CHIP D., Magee. Born Jackson, MS, January 5, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family medicine residency, Same, 1994-97; elected by Central Medical Society.

HOUIN, JEFFREY C., Tupelo. Born Louisiana, January 11, 1965; MD Louisiana State University School of Medicine, New Orleans, LA, 1992; internal medicine residency, same, 1992-93; dermatology residency, same, 1993-96; elected by Northeast MS Medical Society.

HUNTWORK, JOHN C., Pascagoula. Born Milwaukee, WI, May 6, 1948; MD University of Chicago Medical School, Chicago, IL, 1972; interned and internal medicine residency, University of Kentucky Medical Center, Lexington, KY, 1972-75; rheumatology fellowship, same, 1975-77; elected by Singing River Medical Society.

ILERCIL, ORHAN, Meridian. Born USA, April 6; MD State University of New York at Stony Brook Health Science Center, Stony Brook, New York, 1988; interned, general surgery and neurosurgery residencies, Georgetown University Medical Center, Washington, DC, 1988-95; elected by East MS Medical Society.

IRWIN, DONALD BRUCE, Pascagoula. Born Alabama, February 4, 1950; MD, University of Alabama School of Medicine, Birmingham, AL, 1977; family practice residency, University of South Alabama Medical Center, Mobile, AL, 1977-79 and University of Alabama, Birmingham, AL, 1987-88; elected by Singing River Medical Society.

KELLEY, COLIN T., Tupelo. Born Framingham, MA October 30, 1962; MD Edward Hebert School of Medicine, Bethesda, MD 1988; psychiatry residency Eisenhower Army Medical Center, Ft. Gordon, GA, 1989-92; elected by Northeast MS Medical Society.

LASETER, JEFFREY THOMAS, Pascagoula. Born Hattiesburg, MS, March 17, 1965; MD University of Mississippi School o f Medicine, Jackson, MS, 1992; surgery residency, Baptist Hospital, Birmingham, AL, 1992-93; anesthesiology residency, University of Texas Medical Branch, Galveston, TX, 1993-95 and Cleveland Clinic Foundation, Cleveland, OH, 1995-96; pain management fellowship, Cleveland Clinic Foundation, Cleveland, OH 1996-97; elected by Singing River Medical Society.

LIN, ANDREW C., Waynesboro. Born Philippines, April 8; MD Far Eastern University Medical School, Philippines, 1979; internal medicine residency, University Medical Center, Jackson, MS, 1982-85; infectious diseases residency, same, 1985-90; elected by South MS Medical Society.

O'BRIEN, BARBARA C., New Albany. Born Iowa City, IA, September 8, 1959; MD University of Tennessee Medical School, Memphis, TN, 1982-86; interned one year, Baptist Memorial Hospital, Memphis, TN, ; internal medicine residency, same, 1988-91; neurology residency, George Washington University Medical Center, Washington, DC, 91-92; elected by Northeast MS Medical Society.

ONG, MANUEL, JR., Carthage. Born July 8, 1963, Philippines; MD Philippines 1987; internal medicine residency, Metropolitan Hospital Center, New York, NY; elected by Central Medical Society.

PHILLIPS, DENISE E., Jackson. Born Greenville, MS, October 24, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine & ophthalmology residency, University Medical Center, Jackson, MS, 1991-97; melanoma fellowship, University of California, San Francisco, CA, 1992-93; elected by Central Medical Society.

PISCIOTTA, VINCENT J., Biloxi. Born Hammond, LA, January 28, 1964; MD Louisiana State University School of Medicine, New Orleans, LA, 1990; general surgery residency, Charity Hospi-

tal, New Orleans, LA, 1990-92; head & neck surgery, MD Anderson Hospital, Houston, TX, 1992-93; otolaryngology & head & neck surgery residency, LSU Medical Center, New Orleans, LA, 1993-97; elected by Coast Counties Medical Society.

ROBBINS, ROBERT J., Hattiesburg. Born New Orleans, LA, February 1, 1964; MD Duke University School of Medicine, Durham, NC, 1990; surgery residency, Baylor College of Medicine, Houston, TX, 1990-95; cardiovascular surgery fellowship, Ochsner Medical Foundation, New Orleans, LA, 1995-97; elected by South MS Medical Society.

SHINE, KATHLEEN T., Meridian. Born August 21, 1963; MD University of South Alabama, Mobile, AL, 1990; family practice residency, Tuscaloosa, AL, 1990-91; elected by East MS Medical Society.

SIMNICHT, KEITH M., Hattiesburg. Born Biloxi, MS, September 17, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family practice residency, same, 1994-97; elected by South MS Medical Society.

SPEIGHTS, STEVEN E., Jackson. Born Prentiss, MS, August 10, 1967; MD University of Mississippi School of Medicine, Jackson, MS 1993; ob-gyn residency, same, 1993-97; elected by Central Medical Society.

STANDEFFER, WILLIAM C., JR., Meridian. Born New Orleans, LA, September 20, 1963; MD University of Alabama School of Medicine, Birmingham, AL, 1990; orthopaedic surgery residency, Orlando Regional Medical Center, Orlando, FL; sports medicine fellowship, The Lipscomb Clinic , Nashville, TN; elected by East MS Medical Society.

THOMAS, ANTHONY L., Meridian. Born Union, MS, March 2, 1962; MD University of Mississippi School of Medicine, Jackson,

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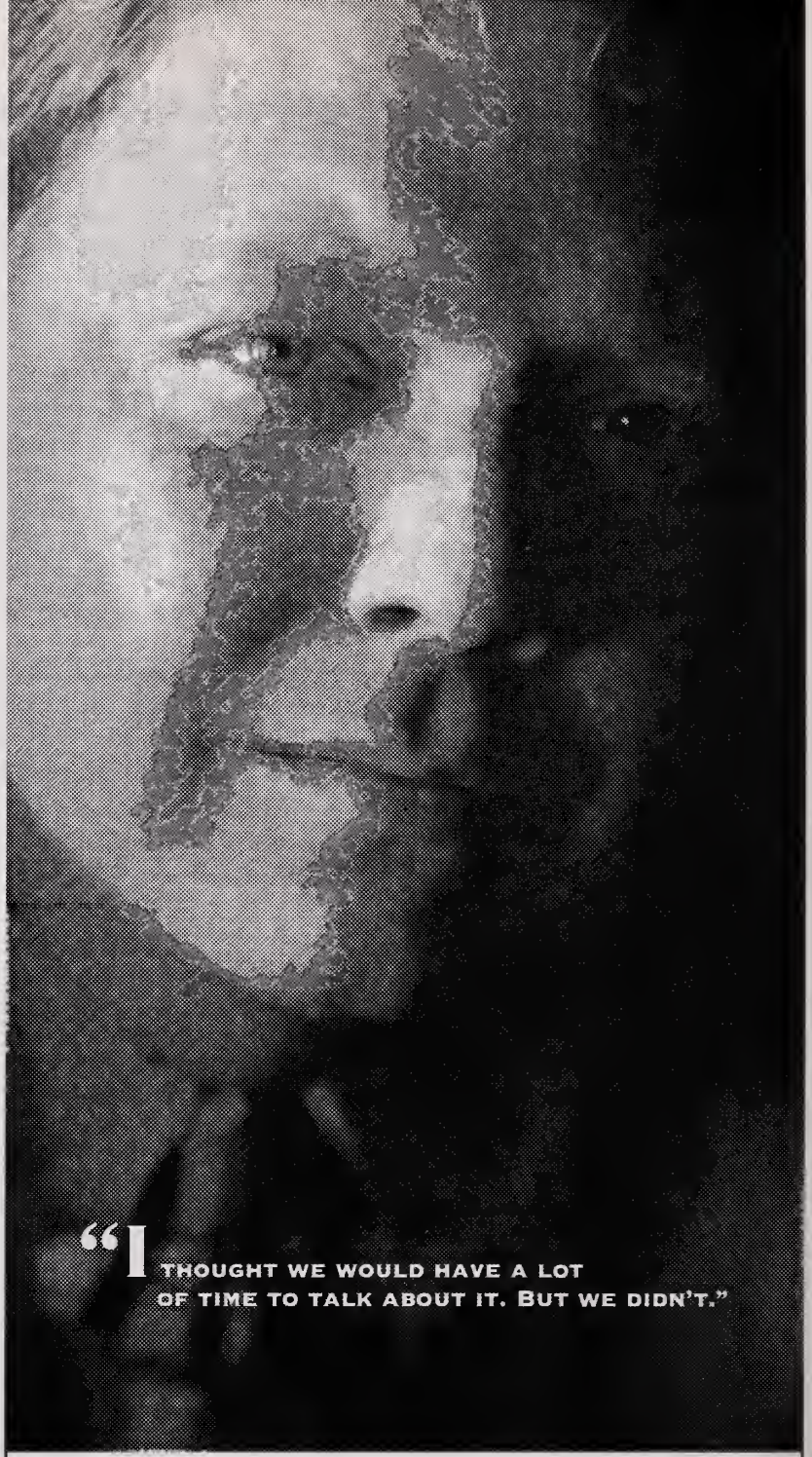
MS, 1988; internal medicine & gastroenterology residencies, Vanderbilt University Medical Center, Nashville, TN, 1988-93; elected by East MS Medical Society.

VIAL, DANIEL FREDERICK, Laurel. Born New Orleans, LA, January 6, 1965; MD Louisiana State University School of Medicine, Shreveport, LA, 1992; diagnostic radiology residency, Texas A & M and Scott White Medical Centers, Temple, TX 1992096; vascular/interventional radiology fellowship, Oklahoma University Medical Center, Oklahoma City, OK, 1996-97; elected by South MS Medical Society.

WASHINGTON, CLINT LEE, Amory. Born Vardaman, MS, June 5, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; family practice residency, Wheeling Hospital Family Practice Residency Program, Wheeling, WV, 1993-96; elected by Northeast MS Medical Society.

WASHINGTON, LAURA L., Amory. Born Columbus, OH, February 27, 1960; MD Spartan Health Science University, Vieux Fort, St. Lucia, 1989; family practice residency, Wheeling Hospital Family Practice Residency Program, Wheeling, WV, 1991-94; elected by Northeast MS Medical Society.

WHITECAR, JOHN P., JR., Columbus. Born Philadelphia, PA, July 17, 1939; MD Jefferson Medical College, Philadelphia, PA, 1965; internal medicine & hematology residency, University of Minnesota Hospital, Minneapolis, MN, 1965-68; hematology/medical oncology residency, M D Anderson Cancer Center, Houston, TX, 1968-70; elected by Prairie Medical Society.



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Kent L. Kebert, M.D. has built a new office. His new address is Kebert Eye Clinic and Optical Dispensary, 1307 Aston Avenue, McComb, MS 39648.

Stanley W. Chapman, M.D., professor of medicine and director of the Division of Infectious Diseases at the University Medical Center (UMC), was promoted to the rank of colonel in the Mississippi Air National Guard during special ceremonies held at the Air National Guard base at Thompson Field in Jackson. Dr. Chapman, a member of the wing for nearly 15 years, serves as commander for the wings 172nd Medical / Dental squadron.

William A. Rock, Jr., M. D., professor of pathology, conducted a workshop at the American Society of Clinical Pathology National Meeting in Chicago.

Greg Redmann, M.D., Ph.D. was recently nominated to the Board of Directors for the Mississippi Chapter of the National Multiple Sclerosis Association.

William B. Geissler, M.D., Chief of Arthroscopic Surgery, Department of Orthopaedic Surgery, University Medical Center was among 72 new members recently elected to the American Society for Surgery of the Hand. The American Society for Surgery of the Hand currently has 1,555 members from the United States, Canada and 35 foreign countries, representing orthopaedic, plastic and Surgery specialities treating diseases and injuries of the hand and upper extremity. Dr. Geissler also recently served as faculty for the American Academy of Orthopaedic Surgeons course on wrist arthroscopy. Dr, Geissler has been reappointed to the Editorial Board of the *Journal of Southern Orthopaedic Association,* in the specialities of arthroscopy, shoulder and elbow surgery, and sports medicine. He has served in this position since 1993.

Eric Enger, M.D. implanted Mississippi's first dual chamber defibrillator July 29 in a 66-year-old Lumberton man. Dr. Enger, a cardiologist, performed the procedure in Forrest General's Cardiac Center of Excellence. The new Ventak AV automatic implantable cardioverter defibrillator system is the first to incorporate a sophisticated dual chamber pacemaker therapy and defibrillation capabilities. The device was approved the last week of July by the Food and Drug Administration. The procedure at Forrest General was just the 10th procedure performed in the United States using the new technology. Dr. Enger is affiliated with Hattiesburg Clinic's Southern Heart Center and sub-specializes in electro-physiology, the diagnosis and treatment of abnormal heart rhythms. The new debibrillator also uses dual chamber pacing therapy that includes mode switching and provides sophisticated therapy for treating fast and slow heart arrhythmias in one device. Makers of the device expect the product to become the system of choice for doctors and hospitals across the country. The device is implanted into the patient's shoulder area.

G. Kermit Till, M.D., has published a novel, *The Bitterroot Wolf.* Now in bookstores in the Jackson area, it deals with the relationship between a young man, Clint Murdoch and a white wolf of the Bitterroot Range. Dr. Till practices family medicine at Rankin Medical Center.

Terrell D. Blanton, M.D. has retired from the Head and Neck Surgical Group in Jackson.

Joseph M. Scoggin, M.D. has been appointed to the medical staff of Trace Regional Hospital. Dr. Scoggin, who was the staff orthopaedist at Oktibbeha County Hospital in Starkville, has joined Trace Surgical Serices located in Medical Plaza.

Chris B. Wiggins, M.D., John W. Cope, M.D. and **Charlton H. Barnes, M.D.** of the Mississippi Coast Orthopaedic Group in Pascagoula announce the opening of their new clinic in Lucedale. Drs. Wiggins, Cope and Barnes specialize in knee and foot injuries and joint and arthritis problems. The clinic will be located in the George County Hospital.

Herbert G. Robinson, III, M.D. has joined Drs. Louis Rubenstein and William Lobrano in family practice at Ocean Springs Family Medical.

Keith Goodfellow, M.D., obstetrician/gynecologist addressed a group of ladies on women's health issues as part of the "Power of Positive Living" seminar program sponsored by the Hancock County Health Council and Main Street United Methodist Church in Bay St. Louis.



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Attention: MSMA Members

The **JOURNAL MSMA** is seeking manuscripts that have not been previously published and are not under consideration by any other publication, submitted in accordance with the guidelines for authors. Articles of medical, socio-economic nature as well as articles of local appeal relative to medical practice in Mississippi are of particular interest. Manuscripts are subject to the reviewing process by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to **JOURNAL MSMA** readers, and usefulness or importance to physicians. Authors are notified upon acceptance or rejection of their manuscript. Contact the managing editor with any questions concerning submission guidelines. Address all correspondence to the Editor, **JOURNAL MSMA**, P.O. Box 5229, Jackson, MS 39296-5229. Phone:(601)354-5433, extension 412.

Dates to Remember

MSMA / MHA
Health Issues Seminar
Legislative Day
January 13, 1998
Jackson

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MSMA 129th
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Announcement

For Sale:

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Price each including tax:

First directory-$53.50, 2-10 copies $37.45; 11 or more-$26.75.

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Nomination
1998 Community Service Award

The **Annual Physician Award for Community Service,** sponsored by Mississippi State Medical Association is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. All nominations should be submitted to the Mississippi State Medical Association by February 26, 1998.

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A $500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

Nominations should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 26, 1998. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.

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The New York Times: In an editorial, the *Times* criticized policy makers who "*...pretend that physician reimbursements can be cut without affecting health care – as if both doctors and hospitals can be slammed without hurting anyone except the providers of care.*"

Physician Payment Review Commission: In its annual report to Congress, PPRC said the current Medicare reimbursement formula for physicians "*...will set increasingly unrealistic target rates of expenditure growth....*"

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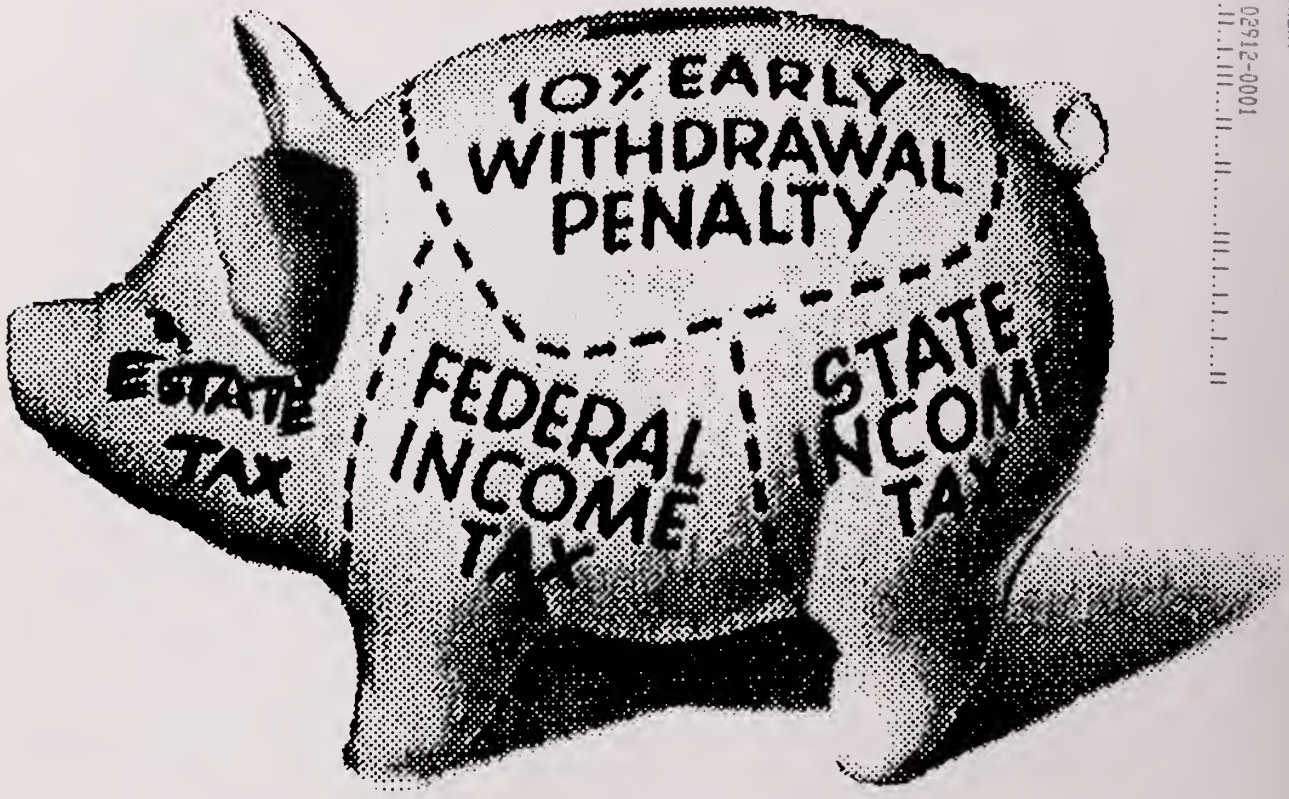
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NOVEMBER 1997

SCIENTIFIC ARTICLES

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The General Management of Acute Poisonings

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Diana, Princess of Whales, Queen of Hearts

EDITORIAL

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Comparison Of Pregnancy Outcome Between Treated And Untreated Women With Chlamydial Cervicitis

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Abstract

Background:

Maternal, fetal, neonatal, and infant outcome in treated versus untreated pregnant women with positive endocervical cultures for *Chlamydia trachomatis* is controversial.

Methods:

One thousand three hundred fifty pregnant women registering consecutively on the staff clinic service were screened for chlamydia. The results of the antigen, but not the culture tests, were available for clinical management.

Results:

Eighty one patients had positive chlamydia cultures, a prevalence rate of 5.1%. Fifty eight patients were not treated, 44 because of false-negative direct antigen tests. Twenty three patients were treated. Maternal complications including abortion, preterm rupture of membranes, preterm delivery, chorioamnionitis, and endometritis were similar in the two groups. Similarly, neonatal and infant complications including prematurity, conjunctivitis, and pneumonia were similar in the two groups.

Conclusions:

Our findings suggest that further prospective, controlled, culture based studies are needed before recommending routine screening for chlamydia even in high risk populations.

Key words:
Chlamydia, Pregnancy Outcome

Introduction

The effect of chlamydial infection on pregnancy remains controversial. Several reports have suggested that untreated maternal cervical chlamydial infection increases the risk of preterm delivery, premature rupture of membranes, and perinatal mortality.[1,4] Others have not been able to confirm these findings.[5,6] Similarly, treatment of infected patients has improved pregnancy outcome in some studies, but not in others.[7-9] While there does not seem to be an increased incidence of chorioamnionitis there may be an increase in postpartum endometritis associated with chlamydial cervicitis.[10,12] Perinatal transmission is associated with neonatal conjunctivitis and pneumonia.[13] Furthermore, the carrier state may be a risk factor for lower respiratory infections after the newborn period. The general prevalence of chlamydial infections complicating pregnancy in the United States is estimated to be 5%.[14] These women are more likely to be young, indigent, and unmarried.[15] In such populations the prevalence of chlamydial infection is likely to be higher. The majority of the women attending the prenatal clinic at the University of Missis-

sippi Medical Center would be judged at demographic high risk for cervical chlamydial infections. In attempting to identify a cost-effective screening program for chlamydial cervicitis in our prenatal clinic population we evaluated two direct antigen detection kits in common use. The results of these assays were available and were used clinically. When these tests were taken samples were also sent to a reference lab for chlamydia culture, these results were not available to the clinician. The assessment of the detection kits has previously been reported.[16,17] However, as a by-product of this study two populations of pregnant women with chlamydial cervicitis were identified, those who were correctly diagnosed and treated, and those who were missed by the antigen tests and therefore completed their pregnancies without treatment. A comparison of the maternal, fetal, neonatal, and infant outcomes in the two groups therefore became possible and comprises the subject matter of this report.

Materials and Methods

One thousand three hundred fifty pregnant women registering consecutively for obstetric care on the staff clinic service at the University of Mississippi Medical Center were enrolled for study. As part of their initial clinical evaluation, a pelvic examination was performed and endocervical samples were obtained for direct chlamydial antigen testing and tissue culture isolation for *Chlamydia trachomatis*. Patients undergoing antibiotic therapy were excluded from the study.

The direct antigen tests used were either the Pathfinder direct fluorescent antigen system or the Testpack chlamydia diagnostic kit. These tests were performed in the clinical laboratories at the University of Mississippi Medical Center and the results were supplied to the physician for on-going patient care. Tissue culture isolation was carried out at the reference laboratory at George Washington University and these results were not available to the clinic physicians. Further details of the collection, transfer, and laboratory testing of the cervical samples are available in our previous publications.

If the result of the direct antigen assay was positive, the patient was treated with oral erythromycin ethyl succinate, 800 mg four times daily for seven days, test of cure was carried out after the course was completed. Chi-square, Fisher's exact test, and ANOVA were used as appropriate in the statistical analysis. A p value ≤ 0.05 was considered significant.

RESULTS

Positive chlamydia cultures were obtained from 81 of the 1,350 patients tested, a prevalence rate of 5.1%. The age range of the women with positive cultures was 13-30, with a mean age of 22. Seventy of these women were African-American, 11 were Caucasian, and payment status was Medicaid in 67, self-pay in seven, and third-party payer in seven. The range of gestational age at which the diagnosis was made was four to 42 weeks, with a mean gestational age of 21 weeks.

Fifty eight patients were not treated and 23 were treated. Of the untreated cases, 40 had false-negative direct antigen tests, two had non-evaluable tests, in five test results were not known. Two patients delivered shortly after testing and nine were not treated because of physician failure to follow protocol. Of the 23 treated cases, 13 underwent tests of cure with seven treated successfully, four responding after a second course of treatment, and two remaining positive after therapy. Ten of the treated patients did not receive a test of cure, two due to empiric treatment, two because of delivery, and six had protocol violations.

The age range of the women who were treated was 13 to 30, with a mean age of 20 compared to 22 years in the untreated group. Patients in both groups were predominantly low income, African-American with a mean age of 21, and supported by Medicaid. There was no difference in the two groups regarding these demographic characteristics. Infant follow-up data from 46 records was recorded with a range of follow-up from six weeks to two years. As with the maternal attendants, pediatricians had access to maternal antigen results only.

Maternal Complications (Table 1). Complications occurred in six of the 23 treated cases (26%). Three women delivered prematurely, one at 34 weeks' gestation with twins, one at 35 weeks' gestation, and one at 28 weeks in whom premature membrane rupture resulted in chorioamnionitis and stillbirth. The remaining three had postpartum infections, one with mastitis, two with endomyometritis, following cesarean in one and vaginal birth in the other.

Table 1. *Comparison of antepartum and postpartum complications between treated and untreated cases of chlamydial cervicitis.*

Maternal complications*	Treated (n = 23)		Untreated (n = 58)	
	Cases	Percent	Cases	Percent
Antepartum				
Abortion	-	-	3	5
PROM	1	5	3	5
Preterm delivery	3	15	7	12
Chorioamnionitis	1	5	4	7
Postpartum				
Endomyometritis	2	8	2	3
Mastitis	1	5	-	-

PROM, premature rupture of membranes.

**Some patients had more than one complication and would therefore be entered more than once.*

Complications occurred in 16 of the 58 untreated cases (27%). There were three abortions, one missed, one at 22 weeks associated with pyelonephritis, and one therapeutic for fetal anomaly. Premature rupture of membranes occurred in three women, two associated with cervical cerclage and one with pyelonephritis. Seven women delivered prematurely including the three with preterm membrane rupture, one induced for preeclampsia, and three with no clear reason for early delivery. Chorioamnionitis complicated four deliveries, one previously mentioned with cerclage and ruptured membranes, and three at term in labor one of whom had appendectomy for periappendicitis in the first trimester. Postpartum endomyometritis complicated two deliveries, one vaginal and one cesarean.

Neonatal Complications (Table 2). Newborn charts were available for review from 75 newborns. Twenty three were delivered from treated mothers. Four of the 23, including a set of twins, weighed under 2500 gm (20%) and one of these, weighing 910 gm, was stillborn. Fifty two babies were delivered from untreated mothers. Seven of the 52 weighed under 2500 gm (14%), three of these exhibited respiratory distress, there was one case each of tachypnea and sepsis. *Infant Complications (Table 2).* Follow-up data were available for review from 46 infants. Fourteen were the offspring of treated mothers. Complications in this group included conjunctivitis in four (one with a positive ocular chlamydia culture, three with negative ocular chlamydia cultures), pneumonia in two, otitis in five, upper respiratory infections in four, and bronchitis in two. Thirty two were the offspring of untreated mothers. Complications in this group included conjunctivitis in two (chlamydia culture positive in both), pneumonia in two, otitis in 15, upper respiratory infections in four, bronchitis in two, and diarrhea in one.

Table 2. Comparison of early and late complications in the offspring between treated and untreated cases of maternal chlamydial cervicitis.

Neonatal complications*	Treated (n = 23)		Untreated (n = 52)	
	Cases	Percent	Cases	Percent
Stillbirth	1	4	-	-
Premature	3	13	7	14
RDS	-	-	3	6
Tachypnea	-	-	1	2
Sepsis	-	-	1	2
Infant complications*	**Treated (n = 14)**		**Untreated (n = 32)**	
	cases	percent	cases	percent
Conjunctivitis	4	28	2	6
Pneumonia	2	14	2	6
Otitis	5	35	15	45
URI	4	28	4	12
Bronchitis	2	14	2	6
Diarrhea	-	-	1	3

RDS, respiratory distress syndrome; URI, upper respiratory infection
**Some patients had more than one complication, and would therefore be entered more than once.*

DISCUSSION

The same group of women at high risk for sexually transmitted diseases, including *Chlamydia trachomatis*, are also the group at high risk for pregnancy and newborn complications. As a result of the high background rate of these problems, identifying a single organism as the causative factor is difficult to either prove or refute. Several studies of the treatment of chlamydial infection in pregnancy have attempted to demonstrate a difference in outcome between treated and untreated cases. These studies too, have had conflicting results.

Ryan et al. compared 1,323 treated women with 1,110 untreated women. Premature rupture of membranes occurred in 5.2% of the untreated versus 2.9% of the treated; birth weight under 2500 gm in 19.6% of the untreated versus 11% of the treated and newborn survival in 97.6% of the untreated versus 99.4% of the treated. There was no significant difference in the incidence of chorioamnionitis. They concluded that routine screening was indicated in pregnant high-risk populations.[18]

Cohen et al. compared 244 successfully treated women with 79 whose treatment was unsuccessful. They found a significant increase in premature membrane rupture and small for gestational age infants in the untreated group. This study was based on antigen detection as the diagnostic criterion without culture verification.[7] Schachter et al. compared the offspring of successfully treated mothers with those of untreated mothers. Of the 59 whose mothers had been successfully treated, one developed conjunctivitis and two developed pneumonia. Of the 24 whose mothers had not been treated one developed conjunctivitis and four developed pneumonia.[19] A similar study by McMillin et al. compared 16 treated offspring, of whom four developed conjunctivitis and one pneumonia, with 21 untreated of whom four developed conjunctivitis and one pneumonia.[20] A third similar study, that of Payne et al., compared 31 treated with seven untreated offspring, each group had one with

conjunctivitis and none with pneumonia, also reported were upper respiratory infections which occurred in 11 of the treated and four of the untreated and otitis media which presented in two of the treated and was not reported in the untreated.[21]

In a related report, that of the vaginal infections and prematurity study, Klebanoff et al. reported a comparison between erythromycin therapy in 938 carriers of group B streptococcus who were randomized to receive or not receive therapy. There were no differences in the occurrence of low birth weight, preterm labor, and premature rupture of the membranes between the two groups. *Chlamydia trachomatis* was cultured in 11% of the erythromycin and 11% of the placebo groups. Ureaplasma was present in 74% of the treated group and 78% of the placebo group. Bacterial vaginosis was present in 13% of both groups. The presence of either chlamydia or ureaplasma did not alter the results.[9]

In view of the conflicting findings of both the observational and interventional studies and in view of the inherent difficulty in identifying a single causative factor in a multifactorial situation with a significant socio-economic background, it seems to us premature to call for the major economic and logistic burden of screening and treating pregnant women for chlamydia even in high risk populations, until larger prospective, culture-based, controlled studies have more clearly demonstrated the advantages of this approach.

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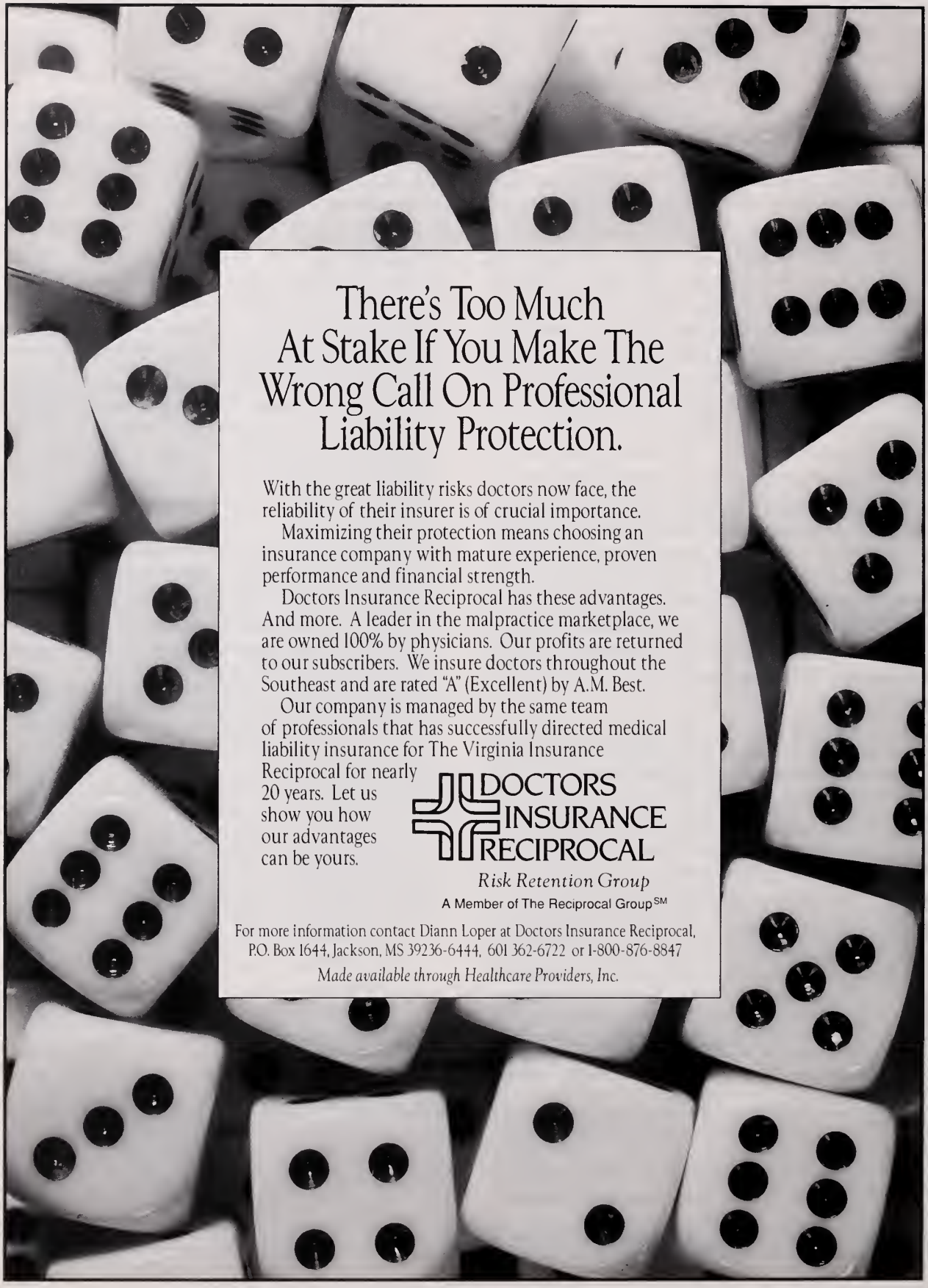
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General Management of Acute Poisonings

F. B. Carlton, Jr., M.D.

Introduction

The general management of the acutely poisoned patient has undergone considerable change over the past decade. A number of well-designed studies have been published that provide direction in the management of this problem and discredit many of the traditional approaches that, although well entrenched and long utilized, have no basis in science.

Accidental or, more commonly, intentional poisonings are common in an emergency department and require the ability to manage patients exposed to a wide array of toxic substances. The specific approach to the poisoned patient will obviously vary with the substance, as well as the clinical presentation. This article is intended to provide general guidelines for the initial management of most poisoned patients.

Key Words: Acute Poisoning
Gastric Emptying
Activated Charcoal
Whole Bowel Irrigation

Resuscitation and Initial Stabilization

If on presentation the poisoned patient's vital signs require support or if coma, obtundation or seizures are noted then these matters *ipso facto* are treated first. A rational approach is:

Airway / Ventilation

Inadequate airway maintenance and ventilation are common problems with many major poisonings, primarily because of decreased consciousness. Any patient who has a significantly depressed sensorium should be intubated. The presence or absence of a gag reflex is not a reliable indicator of the patient's airway status.[1] Some individuals may not be able to protect their airway despite an intact gag reflex, while others normally lack this protective mechanism. It should be noted, however, that poisonings are dynamic and a patient who does not require an artificial airway initially may need one later. Depending on the substances ingested, frequent monitoring is necessary to observe deterioration before a severe decline and disaster occurs.

Circulation

The initial resuscitation of hypotension should be with intravenous fluids. Vasopressors should be withheld unless volume expanders fail to restore an acceptable blood pressure. This is because toxins that cause hypotension by venous pooling far outnumber agents, such as propranolol, that can cause primary myocardial depression. Severe hypertension, if from cocaine, usu-

ally requires only observation although benzodiazepines may be necessary.

Treat Coma

Virtually all patients presenting with coma or obtundation should be given oxygen and either quickly evaluated for hypoglycemia or administered glucose. Two mg of naloxone should be given to anyone with signs or symptoms of significant narcotic overdose. Additionally, if alcoholism or malnutrition is suspected, thiamine 100 mg should be given intravenously to treat or prevent Wernicke's disease.

Treat Seizures

If seizures are present, they should be treated immediately with lorazepam 1-2 mg (0.015 mg/kg in children) over 1-2 minutes. While monitoring the airway, additional doses of lorazepam should be given until termination of the seizures. Phenytoin or fosphenytoin in a dose of 18-20 mg/kg should be administered after the seizure is aborted or if lorazepam fails to terminate the convulsion.

Diagnosis

After attention to the above problems or if the patient presents, as most of them do, in a more stable condition, it is necessary to determine whether poisoning has occurred so that appropriate care can be delivered. Associated illnesses and other causes of altered mental status or seizures, including head trauma, hemorrhage, infection, metabolic disorders and hypothermia should be considered. The diagnosis of poisoning, however, is usually easily made from the history, obtained either from the patient or an accompanying individual. In spite of this, the physician should be wary as histories from overdose victims can be unreliable. Clues from the scene such as empty pill bottles should be sought. Routes other than oral should be considered such as intravenous (drug abuse), inhaled (e.g., carbon monoxide, smoke inhalation) and cutaneous (e.g., organophosphates).

In addition to the routine physical exam, the poisoned patient should be examined for evidence of a toxidrome. A toxidrome is a constellation of signs and symptoms that may reveal what class of chemical or drug is involved. Although the common ones are listed in Table 1, not all agents produce a toxidrome. It must be remembered that if the history suggests one type of poisoning, but the physical exam a different one, the latter is the one to be trusted.

Finally, the requisite lab in a poisoned patient will vary with the clinical presentation and the toxic agent. Some patients require no testing, while others need extensive laboratory evaluation. These tests should be ordered early in the assessment of the patient and might include glucose, electrolytes, renal and liver tests, complete blood count, arterial blood gases, urinalysis, electrocardiogram and radiographs (occasionally including a KUB).

Toxicology screening may prove invaluable on occasion but should generally be ordered only if it will make a difference in therapy or is needed to assist in the differential diagnosis. Levels of toxic substances may be helpful in managing patients (especially ethanol, salicylates and acetaminophen).

Nonspecific Therapy

Emesis

The routine use of ipecac in the emergency department can no longer be justified. While some drug may be recovered with this technique, it does not reduce its area under the curve (the amount absorbed).[2] Moreover, emesis in the emergency department has failed to demonstrate clinical improvement.[3,4,5] This is not surprising given the above data and that the average length of time from ingestion to presentation is approximately 68 minutes for children[4] and over three hours in adults.[5] 4 In addition to increasing the complication rate (primarily aspiration), it delays more effective therapy. Ipecac has been shown to have a mean duration of action of 4.2 hours and to delay administration of activated charcoal by an average of 2.2 hours.[6] Emesis has a very limited role in the emergency department and should be reserved for massive toxic ingestions which cannot be lavaged (e.g. certain toxic leaves) and do not adsorb to activated charcoal.

Gastric Lavage

Optimum use of gastric lavage has been demonstrated to recover approximately one third of the ingested substance.[7] Lavage, therefore, is subject to many of the criticisms of emesis. Gastric lavage has demonstrated clinical benefits only when done in obtunded patients presenting less than 1 hour after ingestion.[8] After making sure the airway is secure, the largest tube possible (a 30 to 40 French in adults) should be inserted with the patient in the left lateral decubitus Trendelenburg position. The lavage should continue until the efflux is clear. Some advocate routine use of charcoal lavage following standard lavage. Gastric lavage is contraindicated if the airway is not protected or in caustic ingestions. Gastric lavage should be considered for toxins unaffected by activated charcoal.

Charcoal

The single most effective agent in the nonspecific treatment of toxic ingestions is activated charcoal and it should be administered as soon as possible. The usual dose is 50-100 gms for adults and 10-30 gms for children. Although there are no absolute contraindications, charcoal has been shown to lack significant efficacy in treating poisonings by mineral acids, alkali, cyanide, DDT, methanol, lithium, malathion and ferrous sulfate. Multidose activated charcoal should be considered for certain ingestions including theophylline, aspirin, phenobarbital.[9] Multidose charcoal appears to act by creating back diffusion into the intestinal lumen.[10] This is accomplished by maintaining the concentration of the drug in the intestinal lumen lower than that in the blood.

Cathartics

Adsorption of toxin on activated charcoal is reversible. By decreasing intestinal transit time, it is theorized that the availability of both adsorbed and nonadsorbed toxin can be minimized for gut absorption. Catharsis, however, appears to have little effect on toxin absorption. Sorbitol (50-130 gms of a 70% solution) is the most rapidly acting cathartic[11] and is used most often. Only one dose of cathartic should be administered, even if multidose charcoal is being given.

Whole Bowel Irrigation

The technique of whole bowel irrigation[10,11] was initially developed as a bowel prep for surgery and later colonoscopy. The preferred solution is a polyethylene glycol electrolyte solution (Golytely©, Colyte©) which is not an osmotic force and has been used safely in pediatric patients as well as adults with compromised renal or cardiac function. The technique involves placing a nasogastric tube and administering 2L/h (0.5 L/h in toddlers and preschoolers) of solution and continuing until a clear rectal effluent occurs which usually takes 4-6 hours. Contraindications include ileus, intestinal obstruction, perforation and significant GI hemorrhage. Whole bowel irrigation should be considered for massive ingestions of agents such as iron that are not adsorbed by charcoal and for delayed release pharmaceuticals. It may also be useful with massive toxic ingestions and late presentations after ingestion.

Enhanced Elimination

These techniques are rarely useful clinically and are affected by the mass and polarity of the poison, its degree of protein binding, and its volume of distribution. Of the therapeutic options available, diuresis with urinary pH manipulation is the one most often used. Urinary acidification, though often discussed, should never be done. However, alkalization can be of benefit in salicylate and phenobarbital poisonings. Sodium bicarbonate 1-2 mEq/Kg given intravenously every 3 to 4 hours is usually adequate to elevate the urinary pH to 7 or greater.

Hemodialysis, once hoped to be a major therapeutic option is primarily useful in managing significant methanol and ethylene glycol ingestions. Severe theophylline, phenobarbital, salicylate and lithium poisonings can benefit from hemodialysis as well.

CONCLUSION:

The management of acute poisonings has changed over the last decade. Gastric emptying is rarely used now because of lack of efficacy and complications. Activated charcoal is the mainstay of general management for most acute poisonings. It is imperative when confronted with a serious, difficult or unfamiliar poisoning that some appropriate reference be consulted, as well as a toxicologist whenever possible.

TOXIDROMES

Anticholinergic
dry skin and mucous membranes, thirst, tachycardia, dilated pupils, fever, cutaneous flush, urinary retention, delusions, hallucinations and ataxia.

Cholinergic
diaphoresis, salivation, tearing, vomiting, diarrhea, urination, bradycardia and mydriasis

Narcotic
CNS depression, pinpoint pupils, decreased respirations and hypotension

Withdrawal
hypertension, insomnia, cramps and diarrhea

Sympathomimetic
CNS excitation, convulsions, hypertension and tachycardia

Extrapyramidal
rigidity, trismus, tremor, torticollis and dysphagia

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The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A $500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

Nominations should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 26, 1998. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.

Coding Concepts

*[Editor's Note: **JOURNAL MSMA** is pleased to present this new feature authored by Wanda L. Adams, CPC. Ms. Adams currently serves on the National Advisory Board of the American Association of Procedural Coders and the Editorial Panel of **MEDICODE** Code Facts. She has conducted MSMA sponsored workshops in Mississippi for physicians and their office personnel.]*

Q. Currently, we are experiencing a difference of opinion in the office regarding when a patient should be considered new. Is a patient considered to be new when he or she presents with a new diagnosis? What about a patient seen in a location other than the office who then comes to the office?

A. According to AMA and HCFA guidelines, a new patient is one who has not received professional services from the same physician or physician of the same specialty. This difference is not based on diagnosis, location of service, or a face-to-face visit. It is simply based on whether or not a physician or physician of the same specialty in your group has provided a professional service within a three-year period.

There are several key points in this statement that should be addressed.

1) Provision of a professional service. This indicates a specific service guideline.

A patient was seen one time only in the office January 5, 1993. The physician refilled a prescription for this patient on April 2, 1993. The patient's next visit to the office occurred on January 6, 1996. How would you classify this visit- new or established? This is an example of "provision of professional services." Since a professional service (refilling a prescription) was provided in April, this visit should be billed as an established patient level of service. The January '96 visit is within three years from the date of the "provision of a professional service" in April.

2) The language "same specialty" is very important since physicians of different specialties are merging into single groups.

For example, a patient was seen by a family practice physician. The patient developed severe abdominal pain. The family practitioner was unable to locate the cause of the problem. The patient was advised to see a partner in the group, a gastroenterologist. Although the physicians' group share staff, office space, charts, and a tax I. D. number, the patient could be classified as a new patient provided the gastroenterologist has not seen or provided a professional service to the patient within the three-year period.

Q. Please advise correct billing for the following scenario. A patient was seen in the emergency department for abdominal pain. The physician who evaluated the patient determined the patient required surgery. What can be billed for this service? Would it be appropriate to bill an evaluation and management code with the surgical procedure?

A. According to AMA and HCFA guidelines, an evaluation and management (E/M) service may be billed on the same day as a major service when the decision to

do surgery is on that day or within a 24-hour period. According to HCFA guidelines, a major procedure is one with 90 days follow up. By AMA definition, a major service is one not classified as minor surgery. Modifier -57, Decision for Surgery, is the communication tool to indicate the actual date the decision was made to provide a surgical procedure.

According to HCFA guidelines, the first twenty-four hours prior to surgery are considered to be part of the global service. When the decision for surgery is within 24-hours of the surgery, the surgeon is entitled to bill for an E/M service since that is the time the decision was made to provide the surgery. Modifier -57 should be placed after the correct level of evaluation and management code.

For minor surgery, use Modifier -25, Separately identifiable service or procedure by the same physician on the date of a procedure or other service.

For HCFA, a minor procedure is one with zero to ten days follow up. According to AMA a minor procedure is one identified by a star or asterisk.

Q. When a pathology report comes back with a diagnosis of malignant neoplasm of the skin, which of the three malignant codes should I use?

A. When pathology identifies the neoplasm as malignant, unless a more specific reference is made by the pathologist or the physician, code the neoplasm as though it were a primary site.

Primary: - Where the neoplasm began

Secondary; Where a neoplasm moved to (metastasize)

In Situ: A contained neoplasm.

Q. According to the Table of Drugs and Chemicals, should the therapeutic E codes be used with poisonings?

A. The therapeutic use column was placed in the Table of Drugs and Chemicals as a means to save space. Otherwise, the table would have had to be reproduced for just that one column. These E codes identify the substance resulting in an adverse effect of a drug correctly administered. These codes should not be used with the codes to indicate a poisoning.

CODING TIP

New patient services are not determined by diagnosis or location of service. The only criteria to be considered are whether or not the patient has received professional services from the same physician or physician of the same specialty in a group setting within a three-year period.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, 3280 Lupine Drive, Arnold, MO, 63010. Please include your name and phone number should additional information be required.

Wanda L. Adams, CPC, Healthcare Consultant and published author *is founder and past president of the St. Louis Chapter of the AAPC. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of MEDICODE Code Facts.*

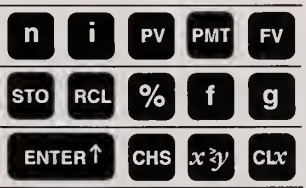
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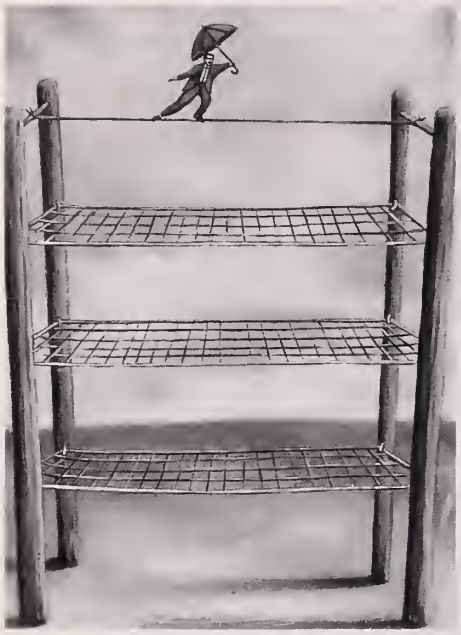
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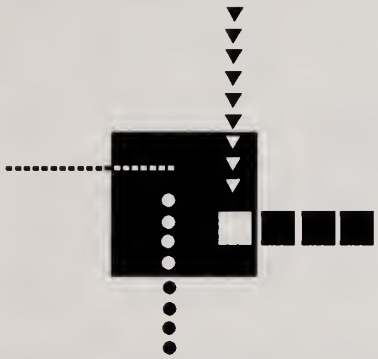
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Your success depends on your involvement! Plan today to attend the 1997 Interim AMA-OMSS Assembly Meeting on December 4-8, 1997, at the Wyndham Anatole Hotel in Dallas, Texas. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 10.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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Doctors as Artists

A very interesting art show was recently presented at Brown's Fine Art and Framing in Jackson. "Doctors as Artists," a group theme exhibit featuring the works of physicians, surgeons and dentists, explored the other side of the doctors, many of whom use art as their creative outlet, therapy, or other form of expression.

"The idea for this showing came from seeing the work of Dr. Edsel Stewart, retired obstetrician-gynecologist, of McComb," says Joel Brown, co-owner and show coordinator for Brown's. "As we have worked together on it, more and more fascinating stories have come out of it and the entire show has just snowballed! It's been quite a popular show."

The "Doctors as Artists" exhibition was comprised of 60 works from 17 doctors from all over Mississippi. They include many who use painting, sculpting, stained glass, or photography as an outlet for creativity or as a release from the stresses of being a surgeon, doctor, or dentist. "It helps them to release stress, but also to fine tune their craft," Brown added, "Especially the plastic surgeons!

"The show is one of the most unique shows we have ever undertaken," said Brown. "Many interesting stories about the backgrounds of the doctors, why they paint what they paint or how they started painting, photographing, or sculpting, have come out of it. One of the exhibitors, Dr. Joel Callahan, survived a plane crash that killed his wife, and he used painting as a form of recovery," adds Brown. Dr. Callahan, a gastroenterologist in Meridian, was given a two percent chance to live after his tragic crash in 1994 and was burned over ninety percent of his body. His recovery was miraculous and he used painting in oil and prints as a way to deal with his circumstances. "As I continued to recover I set new goals. One goal that took about six months was to learn to read," said Dr. Callahan. "In December, 1994, I started painting again, and in October, 1995, I held a one -man art show. To me, a very thrilling and very positive goal had been reached that day."

Dr. Stewart helped to coordinate the doctors with Brown's. "Edsel was the inspiration for the show," says Allison Brown Simmons, co-owner and gallery coordinator for Brown's. "Joel framed some of his works for a show at the Marie Hull Gallery at Hinds Community College and was so impressed with his work, he thought a show was in order. From there he found out there were other doctors who paint, and he just took it from there," Simmons said.

"Dr. Stewart is a well respected Mississippi artist who has painted all his life," said Brown. He has won numerous awards for his work including "Best of Show" from the American Physicians Art Association. Having studied with nationally recognized artists Judy Betts, Doug Walton, Zoltan Szabo, and the late Edgar Whitney, Dr. Stewart's impressionistic paintings of landscapes and ordinary scenes capture the subject in a beautiful way.

While Dr. Stewart is considered a professional artist, Opthalmologist Dr. Keith Everett of Meridian has never really had any formal training in art but said he has "always had an interest in the visual arts." He considers this to be why he chose opthalmology, "since it relates to all aspects of vision." His works depict outdoor scenes of relaxation and some still life's in watercolor.

"Another doctor/artist had the premiere of a sculpture of Andrew Wyeth," related Mary Grace Brown, owner of Brown's. Dr. Kim Sessums, an obstetrician-gynecologist from Brookhaven, whose idol is Wyeth, began a sculpture of him based on photographs, and sent them to him. Andrew Wyeth then called and invited him to come for a sitting so he could "get it right." The sculpture was seen for the first time in this show. Dr. Sessums had a collection of his sculptures as well as of his drawings on exhibit.

Dr. Robert Allen Smith, a well known plastic surgeon from Jackson, is also a very good painter. His works in oil are terrific in their depiction of still life's and architecture. The work in this exhibition ranges from still life's and

figures to garden scenes.

Also from Jackson, Dr. Tom C. Turner, retired orthopaedic surgeon, belongs to the Jackson Photographic Society and the Photographic Society of America. His impressive sculpture of Christ on the Cross, entitled, "On the Physical Death of Jesus Christ," is featured with his photographs

Another photographer, Ear Nose and Throat Specialist Dr. Bill Sneed showed some photographs that he has taken around the world. They have an unusual, sometimes abstract quality about them. His subject matter ranges from floral to architectural and are creative images of everyday objects.

Another Jacksonian, Dr. Owen B. Evans, Professor and Chairman of the Department of Pediatrics at the University Medical Center (UMC) paints oil on canvas and paper. All of the work he has produced has been donated to different local charities, including the UMC Candlelighters. His unique style features everyday scenes of buildings and people. Dr. Evans is a member of many professional associations and he has sponsored research in muscular dystrophy and childhood epilepsy among other diseases.

Also at the UMC, Associate Professor of Family Medicine and Director of Student Services Dr. Judy Gore Gearheart is a painter, potter and sculptor from an artistic family. Her father, Dr. Sam Gore, is head of the art department at Mississippi College. In Brown's show, she showed paintings, terra cotta stoneware and a bust sculpture of her father.

Other doctors/artists in the show included Radiologist Dr. John Gibson, whose pen and ink drawings are precise in their detail and Dr. Allen Hughes of Memphis who has won ten "Best of Show" awards at the National Wildlife Show. He is the only person to win the top category in both painting and carving which he acheived twice.

Dr. Joseph Portera, a dental cosmetic reconstructionist; Dr. Kirby Walker, a retired dentist and Dr. Heber Simmons, a local dentist, also exhibited.



"On the Physical Death of Jesus Christ" by Dr. Tom C. Turner.



Oil and Acrylic Paintings by Dr. Edsel Stewart.



"New Hope," an oil painting by Dr. Joel Callahan.



"Trio," a watercolor by Dr. Keith Everett.



Dr. Kim Sessums' sculpture of Andrew Wyeth and other assorted sculptures and drawings.



Photographs taken by Dr. Bill Sneed.



An oil painting by Dr. Charles Guess.



"St. Louis Cathedral" in New Orleans, an oil painting by Dr. Charles Guess.





Left and above: Dr. Owen B. Evans' unique style in oil features everyday scenes of buildings and people.





Left and above: Dr. Judy Gore Gearheart is a painter, potter and sculptor.



H. Vann Craig, M.D.

The President's Page

Diana
Princess of Wales
Queen of Hearts

Diana, Princess of Wales, Queen of Hearts, Queen of all our hearts! Good-by England's Rose. A meteor across the dark August sky, gone too soon. The outpouring of grief and love from the world precipitated by the death of Diana Spencer is, in my remembrance, without parallel. To my knowledge, at least from what I have read, only the crowds meeting the funeral train of Abraham Lincoln could compare with this. Most of us remember where we were and what we were doing when John Kennedy was assassinated and I dare say we will do the same about Diana.

One of her projects has also been addressed by the AMA House of Delegates- Land Mines. Those defensive weapons used to secure a position against intruders, but so often left behind and unmarked to impersonally kill and maim the innocent in Cambodia, Angola and now Bosnia. Surely the world could do away with these weapons if we would only try.

Impossible you say. Can't be done. Why not? Didn't we agree to do away with poison gas after World War I. Perhaps we, the medical community that treats the injuries, should pick up her torch - or is it a gauntlet she has thrown at our feet - and work to do away with these awful weapons. A journey of a thousand miles begins with one step. If we, as a World, can agree to do away with these weapons, perhaps we could negotiate WAR. If we can do that, there might be hope for tort reform!

Vann

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 11
NOVEMBER 1997

Inappropriate Use of DEA Numbers

On several occasions over the past few months I have received telephone calls from a number of pharmacist requesting my DEA number for use with prescriptions written for non-controlled drugs, usually antibiotics. I thought this to be a rather unusual requirement and decided to find out why this was being requested. I was subsequently informed that this was a requirement of certain insurance companies, and was demanded on all prescriptions written for patients insured by the company. I was further informed that unless I provided my DEA number for such prescriptions that the insurance company would not pay for the prescription, even though such prescriptions are covered by the patient's policy.

The Controlled Substance Act, Title 11, of Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended in 1984, requires strict compliance to DEA regulations such as: Proper initial registration for, and annual renewal of DEA license, separate registration and renewal for each office at which a physician works (when more than one), inventory of controlled substances on hand in office every two years, documentation of purchase and use of all controlled substances in each office, and describes what constitutes a legally written controlled substance prescription. I could not find any information regarding demands for DEA numbers for prescriptions for uncontrolled drugs.

There are federal, state, and local laws regarding control, manufacturing, sale, and dispensing of controlled substances and in any given situation the most stringent of these laws pertaining to any specific substance or situation takes precedence whether federal, state or local.

A check with state and local regulators revealed no regulations relating to the use of DEA numbers for non-controlled substances.

Unable to find any information relating to the unprecedented use of DEA numbers I called the local Drug Enforcement Administration office seeking information and advice. I was referred to the New Orleans office and from there I was informed that the Drug Enforcement Administration considers such use of DEA numbers inappropriate and unauthorized, but that there was nothing they could do about the problem. The agent further explained that several years ago Dunn and Bradstreet Corporation requested a copy of all DEA numbers from the Drug Enforcement Administration. This request was denied, stating that DEA numbers were assigned to physicians and other appropriate professionals for use only in fulfilling the requirements of the laws relating to controlled substances. Dunn and Bradstreet then took legal action against the Drug Enforcement Administration and subsequently the United States Justice Department ruled that the DEA must provide the numbers to Dunn and Bradstreet. In compliance this was done, and as a result of that action all DEA numbers and now in the public domain, and as such are available for use by anyone, or any group, as they desire.

Such uncontrolled, and unregulated, use of these numbers is a gross misuse of the system. Requiring a DEA number for antibiotics or any other uncontrolled drug is abusive. Denial of payment for a prescription covered by one's insurance unless a DEA number is on an otherwise legal prescription is a major cop out, and as such is totally abusive to the patient, the physician, and the pharmacist. Companies interested in tracking such prescriptions should develop some other means of doing so, and legislative controls should be passed to prevent the inappropriate use of DEA numbers. To accomplish this a proper Resolution should be pursued through the Mississippi State Medical Association, asking the American Medical Association to address the issue, and seek legislative changes prohibiting unauthorized use of DEA numbers.

-Myron W. Lockey, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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Dear Doctor Craig:

Thank you for doing your part to promote American Medical Association (AMA) membership in Mississippi. The President's Page in the September issue of the *Journal of the Mississippi State Medical Association* was right on target. I appreciate your much needed support and encouragement in promoting AMA membership among your constituent members.

Today more than ever, our profession must unite with a single-minded dedication to the goal watch all physicians share--better health care for our patients. Never has it been more critical for us to strongly advocate for patients and to exert ourselves in the public policy arena. But to ensure our success, we need the support of every physician in this country working at every level of organized medicine.

Once again, thank you and the Mississippi State Medical Association for your much needed support.

Sincerely,

P. John Seward, MD

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In Honor of Mom, In Memory of Marsha

I wish to tell everyone of a very special and important person in my life that never ceases to amaze me. Many of you know her. I feel that I know many of you on a personal basis because I have heard mom talk of you so much! Barbara Shelton, Nancy Lindstrom, Nancy Bush, Kathy Carmichael just to name a few. My mother, Peggy Crawford, has exceeded my expectations as a mother, woman and human being.

I have always known that she was special, but I have realized it more in the past few years. I would feel honored if I could follow in her footsteps, for even a fractional step of what she has accomplished. You see, mom never stops. When help is needed or a project is in its infancy, Peggy Crawford cannot say no to friends, family and business associates, because she just doesn't want to. If there is a problem to tackle, she is right in the middle of it. When mom was MSMAA President, Dr. Don Mitchell would call her his "cheerleader" because of her willingness to get things done and because of her enthusiasm. I kid you not, mom is the Energizer Bunny and she gives me so much to look forward to in my own accomplishments!

One of the hardest and most meaningful "projects" that mom has had in the past was her Breast Cancer Awareness Project when she was SMAA Health Education councilor for Mississippi. In the initial phases of the project, Marsha, mom's younger sister was diagnosed with BC. Mom was avid about this task. She and Dr. Louie K. Finch pinned over 500 men and women in 4 hours at the Neshoba County Fair with pink ribbons. That is a lot of finger work! 10,000 flyers were placed everywhere in this state from high school locker rooms to store windows! All of the hard work of everyone involved payed off. Mississippi won the Eileen Martin Award for all of the 17 regional states entered in this category.

We all hope that the statistics of 1 out of every 8 women will change. It seems very ironic to me that my aunt found this cancer around the time that my mother started this journey. It is also very ironic to me that mom found out that Mississippi had won regionally when we were at Marsha's funeral.

I love you, mom, and please get your mammogram!

Robin

UMC Medical Students' Spouses' Auxiliary

Recently, a welcome party was hosted for the University of Mississippi Medical Center Spouses' Auxiliary at the home of MSMA Alliance President Jane Ladner in Jackson. The purpose of the organization is to foster a closer relationship between the spouses of students in the School of Medicine and to enable them to work together for the good of the group and for the community as a whole. Activities for the coming year will include: Halloween candy bags for the Children's Hospital, Christmas card drive for the Friends of the Children's Hospital, magazine drive for patients, book donation to the Children's Hospital, bake sales, cooking classes and an interior design show. The Mississippi State Medical Alliance sponsors the membership of student spouses by paying their dues. The sponsored spouses receive information on programs and several publications.



Laura Dyess and Sarah Atkinson are welcomed to the meeting by MSMA President Jane Ladner.



Officers: (back, left to right) Stacy Hontzas, president; Grace Bennett, Deborah Smith, Sarah Atkinson and Debbie Copeland. (Front, left to right) Mary Beth Cantrell, Kathryn McRaney, Amy Womack, Allison Rester and Laura Dyess.



Central Medical Society Co-Presidents (left to right) Rachel Aultman and Martha Smith address the group as President Stacy Hontzas discusses the year's activities.

Physicians Should Recommend Flu Immunization

The seasonal impact of influenza is difficult if not impossible to predict. However, with the cooperation of physicians in Mississippi, it is hoped that the administering of flu shots will greatly diminish the cases of flu this winter.

The Foundation in cooperation with the Health Care Financing Administration is working on a general flu project once again, promoting the importance of the vaccine for every Medicare patient. Through the Horizons project sponsored with Jackson State University's MS Urban Research Center, the Foundation is also emphasizing the importance of the vaccine for the state's African-American Medicare beneficiaries, for whom statistics have reflected very low vaccination rates in years past.

A vital phase of this year's Horizons project is a direct mail campaign with over 40,000 brochures sent to beneficiaries throughout the state. This brochure entitled "Doctors Agree" features three physicians emphasizing the importance of the flu shot. Special thanks go to Dr. Douglas Conner of Starkville, Dr. Gilbert Mason of Biloxi, and Dr. Robert Smith of Jackson for their cooperation. A variety of other promotional materials is available for publicizing the importance of flu shots, and these materials have been made available to physician offices and hospitals.

Dr. Nolan Encourages Cooperation from Physicians

Dr. Rathel (Skip) Nolan, of the Division of Infectious Diseases, Department of Medicine, University of Mississippi Medical Center, urges physicians to make the vaccination available to their patients beginning in October because it has been repeatedly shown to reduce hospitalizations and mortality in the elderly and chronically ill. According to Dr. Nolan:

Influenza vaccination should ideally be administered from October through December, since cases of influenza peak in December and March. Vaccination is indicated for anyone older than 65, those older than six months of age with chronic illness, residents of long-term care facilities and barrier groups, such as health care workers who might infect high-risk people. Vaccination is also indicated for essential community workers or anyone who wishes to reduce the risk of acquiring influenza.

Ten to 20 percent of the population in this country get influenza each year, with 20,000 excess deaths occurring in each of ten epidemics from 1972 through 1991. More than 90 percent of deaths occur in those over the age of 65. Even in mild flu years excess deaths occur. Epidemics in the U.S. cost greater than 12 billion dollars in direct and indirect costs.

Efficacy in preventing illness exceeds 90 percent in healthy young adults. Efficacy in preventing illness falls to 30-40 percent among frail elderly patients; however, influenza vaccine recipients are two to four times less likely to develop pneumonia or die. This vaccination is safe and well tolerated. **Serious adverse side effects are extremely rare.**

Frequently heard reasons for not receiving vaccination include: "I never get the flu" or "I got vaccinated, but I got the flu anyway." It must be remembered that not everyone infected with influenza develops classic influenza syndrome. Some infected individuals may develop an illness indistinguishable from a cold, but are able to transmit this highly contagious virus to others. This is particularly important in health care workers who are capable of spreading the infection to many chronically ill patients. Also,

one can develop a flu-like illness indistinguishable from flu from a non-influenza vaccination. These syndromes, however, are not associated with the same amount of morbidity as influenza.

Anyone older than 65 years of age seen in a physician's office between October through November should be offered influenza vaccinations. It should be strongly encouraged in the chronically ill. The number one reason cited by Medicare beneficiaries for getting a "flu" shot was that their doctor recommended it.

Physicians who have not received order forms for available flu materials for their offices should contact the project manager, Tammy Clark, RN, BSN, at the Foundation, 601-948-8894 or 1-800-844-0500.

-Jim McIlwain, M.D., President

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John D. Bower, M.D., has been honored by the Kidney Care, Inc., Foundation's pledge of a $2 million gift to the University Medical Center (UMC) to establish the Chair of Nephrology and Hypertension in his name. The foundation will make four yearly contributions of $500,000. Dr. Bower, professor of medicine and director of the Division of Nephrology, has been a member of the UMC faculty since 1965. He founded Kidney Care, Inc., in 1973 which was a regional network of artificial kidney units for the treatment of patients with end-stage renal disease. He also received the A. Peter Lundin, M.D., Award from the American Association of Kidney Patients for "significant personal and professional contributions to the care and well being of kidney patients."

John C. Morrison, M.D.; James N. Martin, M.D.; Bryan Cowan, M.D.; and **Richard C. Boronow, M.D.** were selected from among doctors around the country for inclusion in *Good Housekeeping* magazines's "Best Doctors for Women" 1997 list. They were nominated by their peers for being leaders in the field of women's health. The survey asked 260 department chairs and section chiefs in obstetrics and gynecology at major medical centers across the country, "In your opinion, which specialists provide the most expert treatment and are the leading clinicians for diseases in women?" To eliminate bias, doctors were not allowed to recommend anyone at their own institutions. From a list of 1,500 physicians, the 410 cited most often were chosen. Morrison and Martin were listed among the nation's top perinatologists, doctors who specialize in high-risk pregnancy. Dr. Morrison is professor of ob-gyn and chairman of the department at UMC. He has made the magazine's best doctors list every time it has been published. Dr. Martin is professor of ob-gyn and director of fetal medicine at UMC. Dr. Richard C. Boronow is clinical professor of ob-gyn and member of the medical staff at Mississippi Baptist Medical Center. He is also a former UMC faculty member. Boronow, who is now in private practice, was included in the list of best gynecologic oncologists-specialists in treating cancer of the female reproductive organs. Dr. Bryan Cowan is professor of ob-gyn and director of endocrinology at UMC.

Doug Perry, M.D., of the Sebastopol clinic, was honored with a surprise reception sponsored by East Central Mississippi Health Care, Inc. for giving unselfishly of himself for the betterment of his patients.

Richard Hollis, MD, obstetrician-gynecologist, is depicted surrounded by babies in a mural commissioned by the Leadership Monroe team. The painting on the side of an old car dealership on Third Avenue North, painted by Jane Yoe, depicts the different aspects of life in Amory.

George Robinson, M.D. announces his retirement from the practice of internal medicine.

Charles L. "Chuck" McCullouch, M.D. has opened Winston Family Practice in Louisville. He was recruited to Louisville by the Winston County Medical Foundation, the local non-profit operator of Winston County Community Hospital.

W. Briggs Hopson, M.D., of Vicksburg, was honored at the "Dinner of Champions" for his success and achievement in the community by the Mississippi Chapter of the National Multiple Sclerosis Society with its highest honor, the Hope Award.

David Lee Gordon, M.D., associate professor of neurology and director of the acute stroke unit at UMC, is the new president of the American Heart Association's Mississippi Affiliate.

Toxey Morris, M.D., a urologist with HubSouth Urology Clinic of Hattiesburg, has been appointed to the American Urological Association Ethics and Judicial Committee.

Mark Craig, M.D., has joined the staff of The Surgery Clinic of Tupelo, P.A., for the practice of plastic surgery. He receive his bachelor of arts degree in physics from the University of Mississippi where he was a Carrier Scholar and a member of Omicron Delta Kappa Honor Society and Mortar Board. He completed his medical studies, internship and residency program at the University of Mississippi Medical Center, where he also served as chief resident of general surgery. He comes to Tupelo from the Medical College of Georgia, where he was chief resident of plastic surgery. Dr. Craig has served

on the House Staff Board of Directors for the UM Medical Center.

Winfred L. Wiser, M.D., UMC professor of ob-gyn and former longtime chair of the department, will be nominated for the 1998-99 American College of Obstetricians and Gynecologists (ACOG/Wyeth-Ayerst President's Community Service Award, District VII, for outstanding and distinguished service in the area of women's health care. Dr. Wiser, who served for 19 years as chair of ob-gyn, worked to improve the relationship between physicians at the Medical Center and those in practice throughout the state. He also worked to improve postgraduate education to help promote improvement in the overall quality of women's health care in the state and surrounding areas. Through his urging, many residents became members of ACOG's Junior Fellows. Dr. Wiser will be recognized during the Annual Industry and Awards Luncheon of the annual clinical meeting in New Orleans, Louisiana, May 3, 1998.

Olivia Diane Moran, M.D. and **Frank L. Leggett, M.D.** donated their time to help area athletes fulfill the requirements of having a physical prior to participating in sports. They screened and examined athletes through a sports medical clinic sponsored by Prentiss Regional Hospital.

John D. Sobiesk, M.D., has completed the requirements for certification as a diplomat of the American Board of Otolaryngology. Dr. Sobiesk is associated with Hattiesburg Clinic where he is an otolaryngologist.

Joseph M. Scoggins, M.D., an orthopaedic surgeon, has joined the medical staff of Trace Regional Hospital. He is presently the staff orthopedist at Oktibbeha County Hospital in Starkville.

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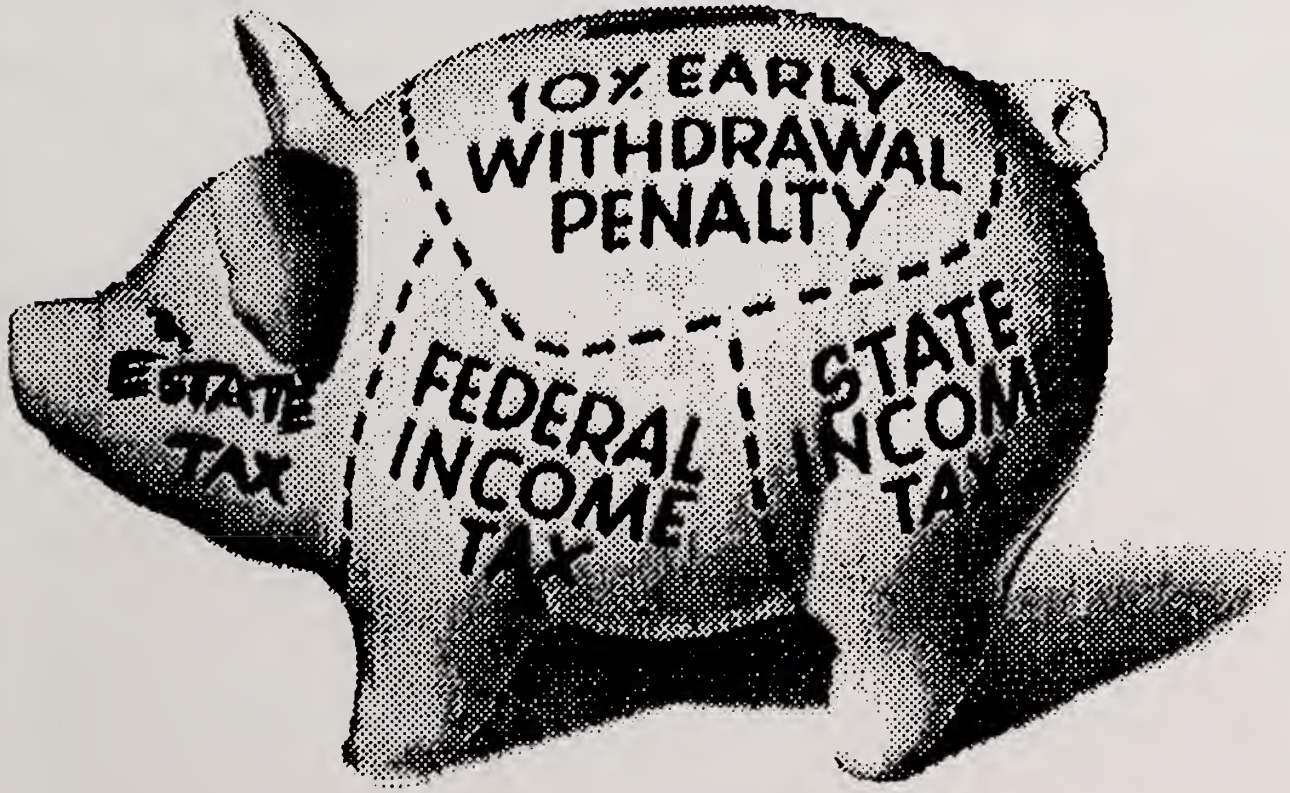
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Sonohysterography: A Unique Technique for the Evaluation of Gynecologic Disorders

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Angina Pectoris From an Unexpected Cause

Kenneth R. Bennett, M.D.
Leonard H. Brandon, M.D.
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Abstract

A 53 year-old-man developed classical angina pectoris, presumably the result of coronary atherosclerosis. Thirty- two years before, an abnormality on a chest film had been described as a "prominence of the upper portion of the left cardiac border." The "prominence" was actually an angiosarcoma, which eventually compromised blood flow in the left coronary system.

Key Words

Angina Pectoris
Heart Tumor
Angiosarcoma
Hemangiopericytoma

Things are seldom what they seem,
Skim milk masquerades as cream.
HMS Pinafore (1878) act II
Sir William S. Gilbert

CASE REPORT

Introduction

Angina pectoris and coronary atherosclerosis are usually considered as one and the same, but this is not always so.

Background

Shortly after enlisting in the United States Navy at age 21, T.W. was found to have an unusual heart silhouette with "prominence of the upper portion of the left cardiac border." In the absence of symptoms related to the chest and of anything unusual in his medical history, the finding was considered to be "most likely consistent with a variation of normal." He was released for unrestricted duty and completed his enlistment without event. After learning that there was something unusual about his heart, he noticed on occasion a dull chest discomfort associated with unaccustomed postures.

At age 30, he experienced a nocturnal episode of "suffocation." No clear explanation was forthcoming, but a chest film again disclosed the unusual heart silhouette. Chest fluoroscopy demonstrated flecks of calcium scattered within an enlarged left heart border, its contour typical of an "enlarged left atrial appendage." Seen by a cardiologist who excluded mitral valve disease by auscultation, he was informed that diagnoses under consideration included calcification within the left atrial appendage, a myxoma or a thrombus, pericardial defect with herniation of the left atrial appendage, or even, perhaps, idiopathic dilatation of the pulmonary artery. Definitive diagnosis, he was told, would require invasive testing, which he declined.

Presenting problem

At age 53, while lifting an arm load of books, he first noticed a "sick feeling" accompanied by precordial and left shoulder discomfort. This progressed over three months to the point that even an ordinary walk required that he stop and allow it to pass.

Compared with previous chest films, which had demonstrated the abnormal heart silhouette, a new film (Fig. 1) confirmed that the heart was enlarging. The only

risk factor for coronary disease was an elevated serum cholesterol (221-250 mg /dl).



Figure 1: *Within the "prominence" of the upper portion of the left heart border scattered calcification can barely be seen.*

The physical examination was unremarkable except for the cardiovascular findings. The blood pressure was 130/80 mm Hg. The jugular pulse was normal. The heart was not enlarged, but a dyskinetic bulge, more prominent during systole, was easily felt just above and medial to the left areola. The heart sounds were normal.

A twelve-lead electrocardiogram exhibited a repolarization abnormality consistent with subendocardial ischemia-injury. There was no evidence for left atrial enlargement. A Bruce treadmill test reproduced the chest discomfort during stage 1, while the electrocardiogram showed a worsening of the repolarization abnormality.

A transthoracic echocardiogram revealed a large ovoid mass containing scattered calcium-like densities, and lying adjacent and medial to the left atrial appendage. For better definition, transesophageal echocardiography and magnetic resonance imaging were accomplished, and these demonstrated a solid mass, likely encapsulated, 8-9 cm in greatest diameter, and clearly outside the heart chambers, resting between the left atrium, pulmonary trunk, aortic root and atrial appendage.

Catheterization demonstrated normal pressures within the right and left heart chambers. Pulmonary and coronary angiography demonstrated a large multi-lobed mass, flecked with calcium, and compressing the proximal segment of the anterior descending and circumflex coronary arteries. From these segments fed numerous tiny vessels, which imparted the "tumor blush" of marked vascularity (Figs. 2,3). The coronary arteries were otherwise normal.

Surgery

The pericardial sac was not abnormal. Inside it was "a considerable amount of clear straw colored fluid." Lying adjacent to the pulmonary artery at the upper portion of the right and left ventricles was a large vascular tumor inseparable from the proximal branches of the left coronary artery. Its vascular nature and tendency to bleed prevented its resection. After multiple biopsies, the anterior descending and circumflex arteries were bypassed with saphenous vein grafts.

Pathology

Microscopic examination revealed a densely cellular tumor with scattered mitotic figures. Slit-like spaces were shown by immunohistochemistry to be lined by Factor VIII positive cells. Stains for cytokeratin, epithelial membrane antigen, leukocyte common antigen, and mucin production were negative. The diagnosis was ***sarcoma with hemangiopericytoma-like features*** (Fig. 4).

Post surgery and final days

The angina pectoris was completely relieved, and all seemed well until eleven months later, when, while lifting a lawn mower, he felt a sudden pain in his back. Magnetic resonance imaging revealed a lesion of the first sacral vertebra encroaching the roots of the first and second sacral nerves. Its histology was identical to the specimens taken from the heart. After a decompression laminectomy he received six courses of adriamycin based chemotherapy, with minimal if any benefit. By the 12th month after surgery the tumor had invaded the right ventricular outflow tract, and by the 15th month it almost touched the left chest wall. With spread of the tumor to the femoral necks, right scapula and spine, radiation was employed to relieve bone pain.

During his 55th year, 34 years after the discovery of the tumor, and 2 years and 3 months after the diagnosis was established, he died suddenly.

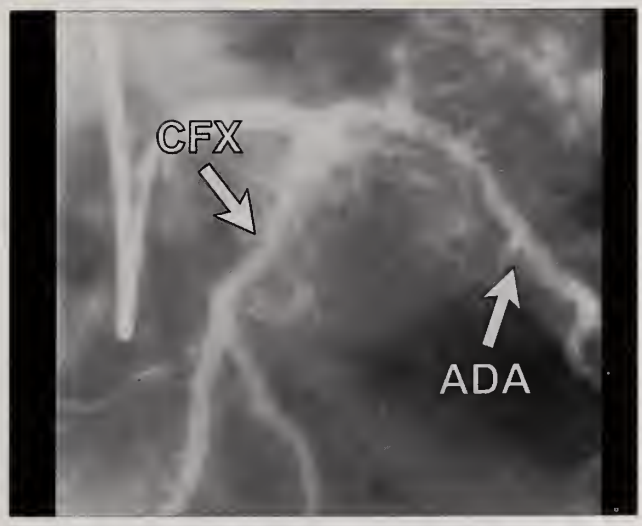


Figure 2: (Top) Left coronary artery in left anterior oblique view. Note markedly narrowed anterior descending artery (ADA) and circumflex (CFX). The circumflex has been displaced medially and straightened by the mass.

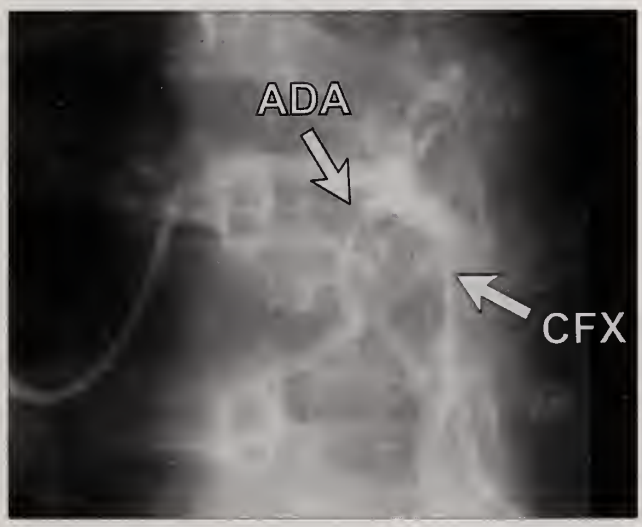


Figure 3: (Middle) Left coronary artery in right anterior oblique view. The "tumor blush" is seen beginning at bifurcation of circumflex (CFX), at tip of arrow (ADA) and extending toward the upper right corner. Note small "feeder" vessels arising from the arteries and the scattering of calcium, best seen at 2 o'clock.

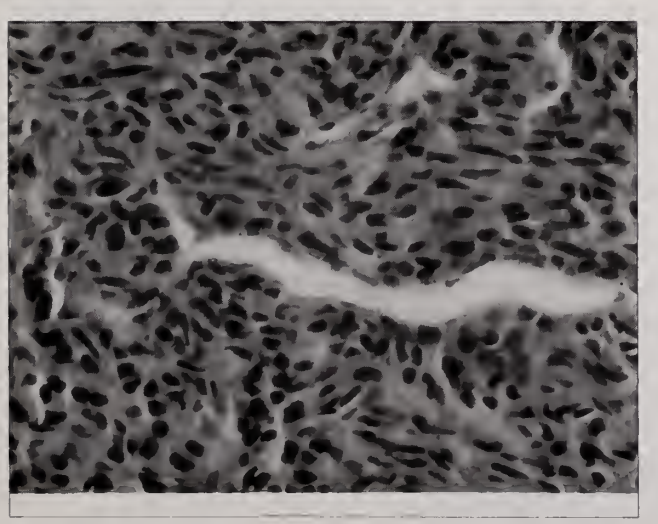


Figure 4: (Bottom) Microscopic appearance: Densely cellular sarcoma with vascular "slit-like" space.

DISCUSSION

Several characteristics of this tumor warrant close attention: firstly, its extreme rarity, secondly, its distortion of the cardiac silhouette to resemble left atrial enlargement, thirdly, its flow limiting compression of coronary vessels to cause angina pectoris, fourthly, the pattern of calcification and, finally, its long latency. If initially benign, when did the tumor first exhibit malignant behavior?

The unusual heart silhouette

The left border of the normal heart is slightly concave, but with enlargement of the left atrium or its appendage (auricle), the border first straightens, then becomes convex and potentially quite prominent. Left atrial enlargement of this magnitude is usually due to mitral disease, particularly stenosis; and the association is so firm that, while there are several other conditions in which the chest film resembles mitral disease, the interpretation is invariably "left atrial enlargement."

Best known of these conditions is congenital failure of the pericardium fully to enclose the left heart. Through this defect the atrial appendage, the pulmonary artery, a part of the left ventricle, or even the entire heart may herniate. Deaths resulting from incarceration of the heart or the coronary arteries have been reported.[1]

Protruding beneath an intact pericardium, an aneurysm of the left atrial appendage may be radiographically indistinguishable from the partial pericardial defect. This rare disorder, presumed to be congenital, has been associated with atrial arrhythmia, thrombus within the aneurysm and arterial embolism.[2]

Pericardial cyst and idiopathic dilatation of the pulmonary artery are rarely of clinical consequence apart from their presence as considerations in the differential diagnosis of a prominent left heart border.

Angina pectoris

The chest discomfort was angina pectoris. The relation of pain to exertion, the repolarization abnormality of both resting and exercise electrocardiograms, and the relief afforded by coronary bypass combine for a "textbook" description.

With no intrinsic coronary disease to account for the angina, the tumor remains the sole explanation. When malignant disease involves the heart it rarely causes angina pectoris or infarction; when it does so, it is by encirclement and constriction of a coronary vessel as in this case.[3]

The tumor

The "true" prevalence of ***primary cardiac tumors*** is not known, but they are not common. Data from 22 large autopsy series indicate an incidence of about 0.02% (200 in 1 million autopsies).[4] Among adults, about one in four primary cardiac tumors are malignancies. As a rule, they are rapidly fatal, and it is unusual for the diagnosis to be made before death.[5,6] ***Angiosarcoma,*** the most common, accounts for about one-third of the malignancies. Eighty percent of the angiosarcomas are found in the right heart chambers, particularly the atrium, and they frequently invade the pericardium.[7,8]

Among angiosarcomas ***hemangiopericytoma*** is the rarest. Of 39 angiosarcoma specimens in the Armed Forces Institute of Pathology series, only 1 hemangiopericytoma was identified.[7]

The neoplasm may have been present since childhood, perhaps at birth, but malignant tumors are uncommon in children, accounting for less than 10 percent of primary cardiac neoplasms.[7] By age 21 it was large enough to distort the cardiac silhouette; and between ages 49 and 53 chest films confirmed significant growth. Markedly aggressive behavior followed surgery, as if the equilibrium between the tumor and host defenses had been upset.

Calcium deposits

Chronic rheumatic mitral valve disease is the most common cause of calcium deposition in the left atrium. Typically plaques line the walls of the atrium or its appendage, and trace the outline of these structures rather than the scattered pattern noted in this case. However, if thrombi within the atrium organize and calcify, as is common in chronic rheumatic rnitral disease, the appearance may be quite similar to that seen in this account.[9]

Some tumors calcify, but this is not a feature of angiosarcomas.[6,7] Calcification is more likely with ***benign*** growths, being present in about 10 percent of myxomas. It is frequent in the center of fibromas, particularly those that outgrow their blood supply.

Teratomas consist of tissue derived from all three germinal layers, and may contain bone or teeth. They characteristically arise from the base of the heart and are usually attached to the root of the aorta and pulmonary artery.[7]

Tumor imaging

Although echocardiography was helpful, magnetic resonance imaging provided more definitive information both before and after surgery. It appears to offer the best means to differentiate normal from abnormal tissue, to determine the structural characteristics and anatomical relationships of adjacent cardiovascular structures, and to evaluate these tumors' response to therapy.[10]

Concluding remarks

At first, angina pectoris was attributed to coronary atherosclerosis. The chest film abnormality was thought to represent a calcified thrombus lodged either within an aneurysm of the left atrial appendage, or, what is more likely, within a portion of the appendage that had herniated through a partial pericardial defect.

Before the operation it was clear that the mass lay outside the heart, did not involve the left atrium or its appendage, was fully enclosed by an intact pericardium and, owing to its location at the heart's base and the prominent scattering of calcium (bone?, teeth?), was thought most likely to be a teratoma.

This account should remind us of the debt we owe our patients, for without them we would learn nothing.

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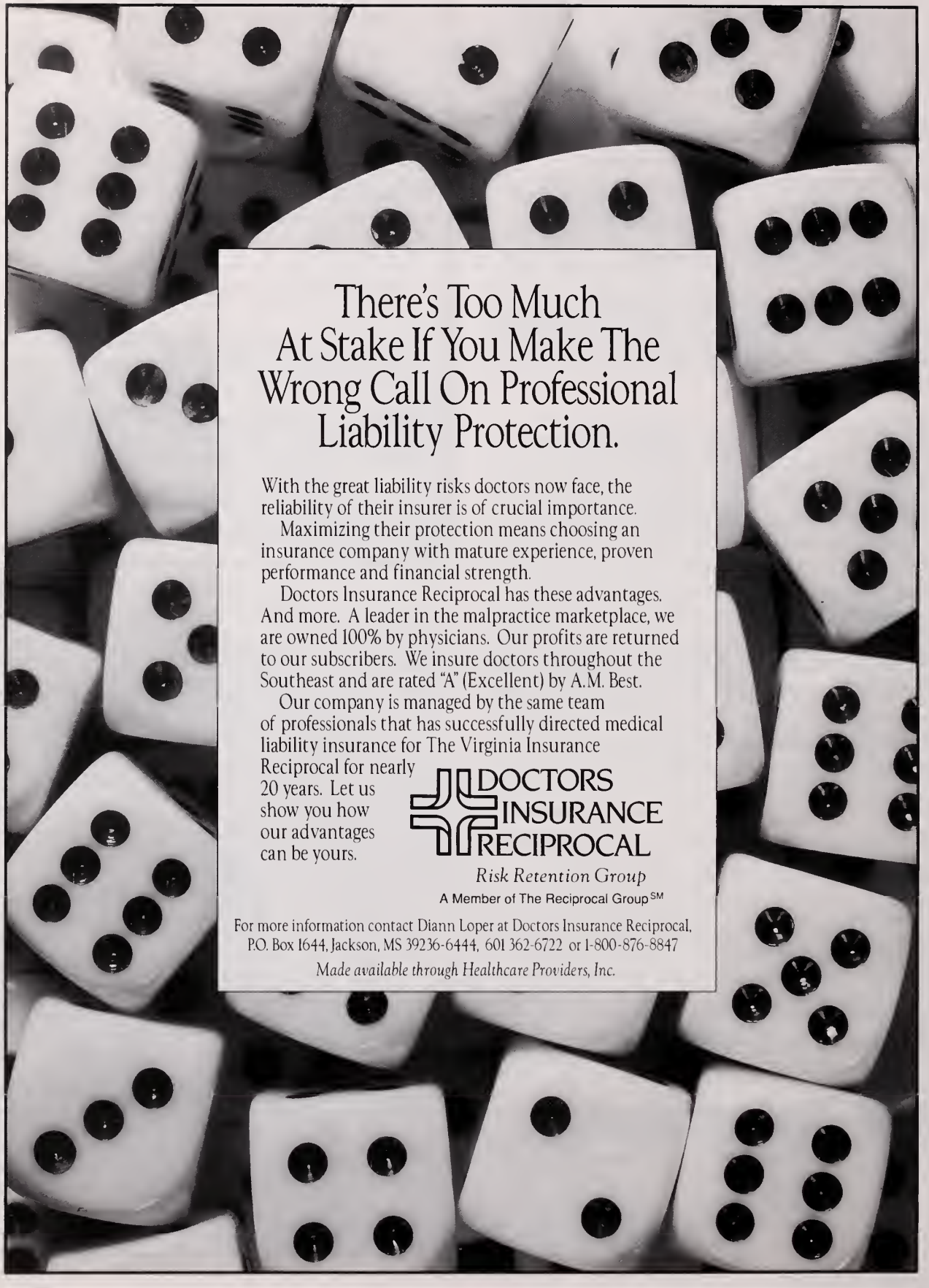
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Sonohysterography: A Unique Technique for the Evaluation of Gynecologic Disorders

John D. Isaacs, Jr., M.D.
Randall S. Hines, M. D.
Bryan D. Cowan, M. D.

INTRODUCTION

Common gynecologic disorders such as abnormal vaginal bleeding and infertility are often due to structural abnormalities of the uterus. Transvaginal ultrasound has revolutionized the evaluation of these disorders. The images produced by the vaginal ultrasound transducer in close proximity to the pelvic viscera allow for non-invasive visualization that previously could only be obtained through surgery (Table I). This office-based diagnostic evaluation allows the practitioner to accurately identify the etiology of many common gynecologic disorders, provide therapy, and ultimately improve patient outcomes.

Although transvaginal ultrasound provides excellent images of the uterus, subtle abnormalities of the endometrial cavity are difficult to visualize. Submucous myomas, or endometrial polyps, etiologies of abnormal bleeding, infertility, and repetitive pregnancy loss, may not be identified with standard ultrasound techniques.

To precisely define intracavity lesions with minimally invasive techniques, sonohysterography has been developed. This procedure employs instillation of fluid into the endometrial cavity to separate the borders of the endometrium. Inapparent structural lesions are thus revealed. The purpose of our paper is to describe the technique of sonohysterography and share our experiences to date with the medical community.

Key words: sonohysterogram, ultrasound, uterus, diagnosis, endometrium

TECHNIQUE

A standard transvaginal ultrasound examination is first conducted. The pelvis is surveyed and abnormalities of the cervix, uterus, fallopian tubes, and ovaries are noted. A sterile speculum is then placed in the vagina and the cervix prepped with antiseptic solution.

A flexible catheter is inserted through the cervical canal to the level of the internal cervical os. We have employed a balloon type catheter (Ackrad Co., Cranford, NJ; Model # 61-3005-5F) to partially occlude the cervical os and allow for distention of the endometrial cavity. Visualization will be greatly improved if the balloon, filled with fluid, is located within the cervix rather than within the endometrial cavity. Additionally, air in the balloon will transmit the sonic waves poorly and introduce artifacts on the viewing screen. We have also used a catheter (Cook Co., Spencer, IN Model # JGSHC502620) which occludes the external cervical os with an "acorn" and eliminates the balloon artifact entirely.

The speculum is then removed and the ultrasound

transducer is introduced. An assistant slowly injects isotonic fluid (D_5W, saline) using a 20 cc syringe connected to the catheter via an extension set tubing. The cavity is then seen filled with fluid. A survey of the endometrium is conducted to identify filling defects. We perform a scan in the longitudinal and transverse planes.

Figure 1 demonstrates the appearance of a normal endometrial cavity utilizing this technique. Most patients describe little discomfort with this technique. Also, most of our patients have stated that they enjoy seeing the images which are readily appreciated on the ultrasound screen and indicate that it is much less painful than hysterosalpingography, the standard method for evaluating the uterine cavity.

Tubal patency can be assessed in some cases by watching fluid and/or air bubbles move into the uterine cornu and out into the tubes. Additionally, fluid can sometimes be seen to collect in the pouch of Douglas and serves as presumptive evidence of tubal patency.

INDICATIONS

A variety of gynecologic conditions can be evaluated with this technique. Table II summarizes some common indications for sonohysterography. These conditions are similar to those that are evaluable by diagnostic hysteroscopy. Sonohysterography can readily expose intrauterine adhesions, submucous myomas, polyps (Figure 2), or an intrauterine septum. This approach is helpful in triaging patients prior to therapy.

UMC EXPERIENCE

Table III reflects our experience in the Division of Reproductive Endocrinology at the University of Mississippi Medical Center in 46 patients who have undergone saline infusion sonohysterography. We have used this procedure to investigate a number of common indications and the findings are detailed in the Table III. We have found this technique to be easy to perform, much better tolerated by the patient than hysterosalpingography and to date all abnormal sonohysterography findings have been corroborated at the time of surgery. Currently, our chief indication for this procedure is the evaluation of infertility associated with an abnormal screening ultrasound. Common findings include submucous myomas, and abnormally thickened or asymmetric endometrium consistent with an endometrial polyp.

Additionally, this technique has proven useful for evaluation of patients with recurrent pregnancy loss who need an evaluation of the endometrial cavity, and those with abnormal uterine bleeding.

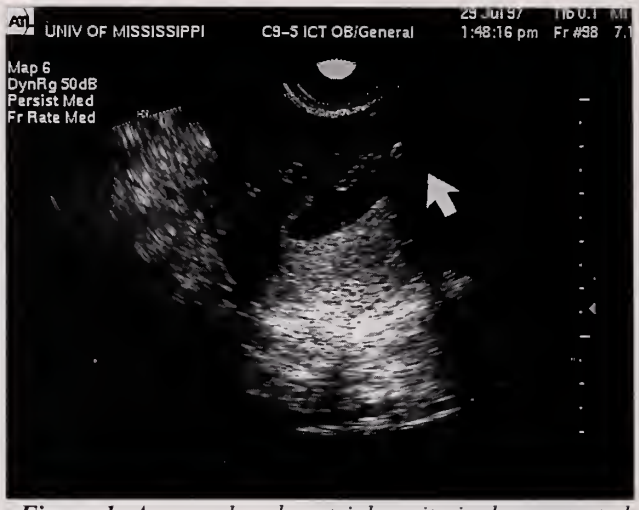


Figure 1. A normal endometrial cavity is demonstrated. The arrow indicates the balloon present in the cervix.



Figure 2. An endometrial polyp and its' stalk are clearly defined by the surrounding fluid during sonohysterography (black arrow).

CONCLUSION

The introduction of vaginal ultrasound has greatly improved the gynecologist's ability to diagnose and treat conditions which previously resulted in continued infertility, abnormal bleeding or hysterectomy. Transvaginal ultrasound is a screening procedure which requires diagnostic hysteroscopy for definitive diagnosis. With the introduction of sonohysterography, the physician can define structural lesions associated with common gynecologic disorders. This procedure is much better tolerated and less expensive than diagnostic hysteroscopy or hysterosalpingography. Our initial experience with this technique has been favorable and it has become a valuable adjunct to the office evaluation of gynecologic disorders.

Table I. Common gynecologic conditions diagnosed with vaginal ultrasound.

Uterine fibroids
Ovarian pathology
Pregnancy
Intrauterine
Ectopic
Mullerian anomalies

Table II. Indications for sonohysterography.

Abnormal vaginal bleeding
Uterine fibroids
Recurrent pregnancy loss
Mullerian anomalies
Abnormal vaginal ultrasound
Infertility
Intrauterine adhesions

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Table III. UMC experience with sonohysterography.

	FINDINGS				
Indication	Fibroids	Endometrial Polyps	Normal	Intrauterine adhesion	Mullerian Anomaly
Abnormal bleeding (N = 16)	6	7	3		
Recurrent pregnancy loss (N = 13)	1		7	1	4
Infertility (N = 15)	7	3	3	2	
Other (N = 2)					2

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Nomination
1998 Community Service Award

The **Annual Physician Award for Community Service,** sponsored by Mississippi State Medical Association is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. **All nominations should be submitted to the Mississippi State Medical Association by February 26, 1998.**

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A $500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

Nominations should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 26, 1998. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.



H. Vann Craig, M.D.

The President's Page

Them

One of the hats I wear on your behalf is that of Chair of the Benefits Committee of MSMA Benefit Plan and Trust - our health plan that is now in its 15th year of operation. In that role I am allowed to attend meetings of THEM - the Health Care Insurance Industry. In that role I am not allowed to register or readily identify myself as a physician so that I will not be perceived as a spy. The meetings are interesting in that I am allowed to view THEIR way of thinking and trends in Health Care Insurance Administration.

The decisions that the Benefits committee makes are frequently not popular ones. They are made from the point of view of what is best and fair as a business. With the cost shifting in the present market, we too are moving to contracts with Hospitals and the Physician Preferred Provider panel of MPCN as a method of controlling the ever increasing cost of medical care. I guess that makes us one of THEM.

You may not be able to attend a meeting of THEM to find out the latest plan to cut costs, but you can attend the AMA Interim meeting in Dallas - an easy drive for most of us - December 7 - 10.

There you can hear from those of us who are exposed to THEIR thinking and learn what is down the road. You can also see Democracy in action at the Reference Committees and on the floor of the House of Delegates. It just might change your thinking about the AMA and some of its policies!

Make your plans now to attend and I will look for you there!

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXVIII, NUMBER 12
DECEMBER 1997

A Bureaucrat Lights His Cigar

I've written before about Medicare's documentation requirements for evaluation and management services. It is time again. Several years ago HCFA released detailed guidelines on the documentation necessary to prove one had actually performed the service for which Medicare was to be billed. The guidelines, involving general multi-organ system exams, were hopelessly complex. It all seemed to revolve around bullets, elements, shaded boxes and unshaded boxes, and if you've never read the guidelines they will not become any clearer than that even if you do read them. I am reminded of the 1950's television character who declared to a friend that progress was such that in the future, everything would be described in terms of neutrons, protons, Fig Newtons and morons.

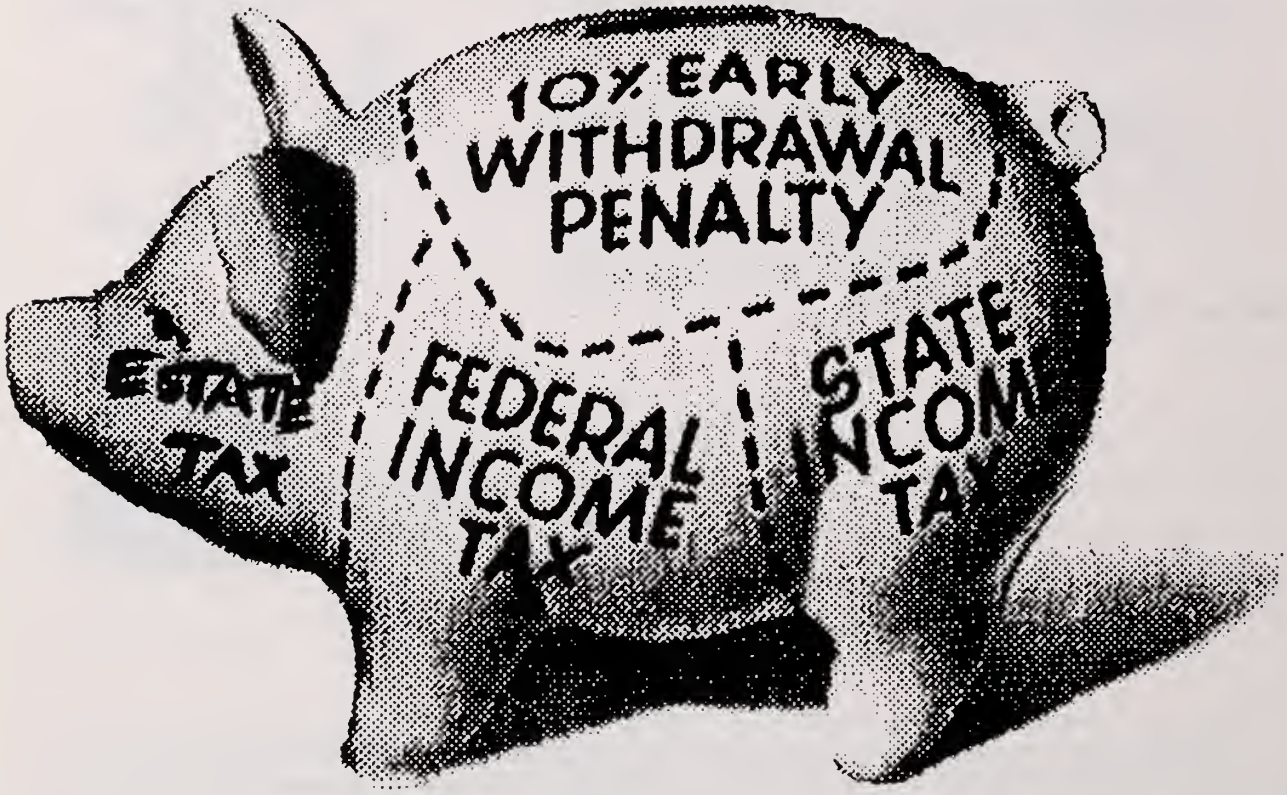
Though I made a sincere effort to comply, I'll admit I have fallen short. There is always some cursed bullet to be forgotten. But instead of simplifying them, HCFA has produced new guidelines for single system exams for specialists, probably more complex than the original ones for multisystem exams. They require, for example, urologists to examine the thyroid gland.

This is hopeless. Medicine is too complicated to be approached with rigidity of this magnitude. The guidelines push us dangerously toward thinking more about what goes onto paper than what goes into the patient. And to think a layman, a bureaucrat, will be the one to sit down with a record and decide if all the elements and unshaded boxes are accounted for. It's enough to drive a strong willed man to the bottle. Maybe it is time, as detestful as it sounds, to have a single fee for a patient encounter, whether of one minute duration or one hour, and leave the documentation to the discretion of the physician.

-Leslie E. England, M.D., Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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Inappropriate Use of DEA Numbers

In response:

In his very timely editorial in the November, 1997, issue of the ***Journal of the MSMA***, Dr. Myron W. Lockey calls attention to the abusive, intrusive practice of some insurance carriers who threaten to deny payment for a covered patient drug benefit if the physician refuses to provide his/her Drug Enforcement Administration (DEA) number, even though the prescribed product is not a controlled substance. Such practices by an increasing number of third party payers and others are nothing short of extortion, and Dr. Lockey concludes his editorial by calling for the MSMA House of Delegates to consider a resolution asking the AMA to pursue legislation barring the inappropriate use of DEA numbers. I thought I would utilize the opportunity afforded by Dr. Lockey's editorial to review AMA policy and actions by its House of Delegates on this important issue.

The problem of inappropriate uses of DEA numbers was first considered by the AMA House of Delegates at the 1989 Interim Meeting, resulting in adoption of the following resolution:

> *RESOLVED, that the AMA (1) believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; and (2) believes that insurance companies and pharmaceutical companies should use a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved.*

This resolution was subsequently reaffirmed by the House of Delegates at the 1996 Annual Meeting.

At the 1993 Annual Meeting the House of Delegates adopted the following substitute resolution;

> *RESOLVED, that the AMA, in order to protect patient confidentiality and to minimize administrative burdens on physicians, will work to eliminate requirements by pharmacies, prescription services, and insurance plans to include such information as ICD-9-CM codes, DEA numbers, and diagnoses on prescriptions.*

The following year, at the 1994 Annual Meeting, the House of Delegates adopted another resolution dealing with the utilization of DEA numbers:

> *RESOLVED, that the AMA affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data.*

Two years later, at the 1996 Annual Meeting, the House of Delegates reaffirmed this resolution.

Unhappy with the continued demand by some payers for the physician's DEA number, New Jersey's AMA Delegation, at the 1997 Annual Meeting, introduced a resolution calling on the AMA to inform the DEA of these practices. In its' report to the House of Delegates the reference committee to which the resolution was assigned for discussion and recommendation noted that there was a great deal of confusion about the legitimate uses of DEA numbers, including their inclusion in the AMA's Physician Masterfile. The report further stated that the DEA numbers maintained in the Masterfile were released by the Association only to authorized end-users in order to assure the integrity of the information and the rights of the physician.

In light of this confusion about the variety of uses to which DEA numbers may be put, the reference committee recommended that the New Jersey resolution be referred to the Board of Trustees for study and report back to the House of Delegates at the 1997 Interim Meeting. The Board's report and further action by the House of Delegates on this recurring problem will be reported in the next issue of the ***Journal of the MSMA***.

William F. Roberts,
MSMA Assistant Executive Director
and General Counsel

Your Time is Past

A shocking thought to contemplate, especially if you are fifty something and still busily practicing medicine. Such a statement is even more disturbing when it is found within the context of an anonymous letter, evidently from a younger colleague, distributed among the mailboxes at your local city-county hospital. The manly, young scribe even went so far as to follow the above statement with, "Please have the good grace to step to the sidelines and let those of us in mid-career or younger fight our own battles. To be blunt sir, sit down and shut up."

It is disconcerting to see how deeply the business of medicine divides us when we become focused upon the personal financial protection (real for some physicians, illusionary for others) to be had by formation of liaisons with hospitals, whether in the form of foundations or HMOs. We once were a proud profession, a collegial body of hard-working professionals who were advocates for our patients. We accepted such financial gains as flowed our way as a natural result of our individual efforts. Due to factors mostly beyond our control such as government intervention, isolated instances of greed among our own peers, and pressure from the insurance industry we are forced into unwelcome and threatening change. Physicians must now consider their future financial survival. The reaction to these pressures has on many occasions been rather knee-jerking and thereby unsuccessful. Instances have been reported throughout the country of the hasty and ill advised organization of IPAs or PPOs which subsequently did not perform as expected. There are yet more recent efforts to establish HMOs for the pecuniary benefit of a few at significant risk of all who join. Those of us who ask the hard questions openly disagree with highly paid consultants, or simply ask for clarification before jumping into such enterprises, are told, "your time is past." I beg to differ.

The anonymous penman mentioned above wants to join with his young peers and "fight their own battle." I would be happy to let them except that I still feel his battle is part of my war. My war, as it always has been, is against those that would dilute the quality of medical care for my community, patients, friends, and family, under the guise of "cost effectiveness." Dedicated physicians and patient advocates have always tried to be cost effective, they don't need to be coerced into such practices.

Some of us have been around long enough to see that sweeping and ill thought out changes in the manner of health care delivery can easily become ingrained and difficult to modify. One such example is Medicare which was vigorously opposed in the early 1960's by many older and experienced members of the medical profession who said that in the long run the country could not afford it and that it would be utilized and even overutilized by a growing population of senior citizens. I ask my younger colleagues, who was right, those experienced physicians who questioned the establishment of such a program or the politicians who finally crafted it? I know that things we physicians might do today impact the finest medical care delivery system in the world and that the effect of these changes, even on a local level, will be in place long after I reluctantly retire. I will continue to express my doubts and concerns and will continue to ask my questions, asinine, anonymous letters not-withstanding. Those of us who have really "been in the trenches" know that some things more important than our fees are at stake.

Donald A. Hopkins, MD, FACS
Gulfport, MS

The comments expressed in this Journal are those of the indicated author. Comments and opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit comments for publication regarding any opinion expressed or information contained in the Journal.

HMO Figures More Troubling News for Poor

Not Enough of Budgeted Money Appears to be Filtering Down to Patient Care

"Old age. It's not for sissies," read the message on the cap of the grandpa across from me at the gas station a few weeks ago.

I don't expect anybody to print it on a hat, but being poor isn't a cakewalk, either.

Assuming there is a government assistance program designed to help, it seems these days more and more hands dip into the pot before the cash gets where it's needed.

Preliminary numbers - and I stress preliminary - from Mississippi's venture into Medicaid HMOs are illustrative. The president of the Mississippi State Medical Association, probably no friend of HMOs anyway, said he was "astonished."

The headline is this: "Three of four Medicaid HMOs spend less than two-thirds of income on patient care."

Put another way, of each public dollar allocated to these private groups, more than 33 cents went somewhere other than to a hospital, clinic, doctor or laboratory.

A lot of people get turned off when it comes to the alphabet soup of modern health care, but the situation isn't really complicated.

Under the fee-for-service approach, specified medical services are available for specified payments for a Medicaid-eligible person. No one particularly likes this approach, especially financial planners. It leaves costs open-ended, dependent entirely on how many eligible people get sick or hurt, what kind of treatment is ordered for them, how many times they go to the doctor and such.

So, the idea of a Medicaid HMO was born. Four-years ago Mississippi lawmakers authorized pilot programs to see what would happen.

Private companies bid to enroll Medicaid-eligible people. Then, for each eligible person enrolled, Medicaid paid the company a flat, "capitated" fee.

Financial planners loved this approach. They knew exactly what their exposure would be. Budgeteers liked it because it controlled costs. Not a factor has been whether people who need health care are getting the health care they need.

In the pilot counties for 1996, three of the companies - American Medical Plans of Mississippi, Family Health Care Plus and Mississippi Managed Care Network - had 752 clients, $174,630 in revenue to serve those clients and spent only $99,237 doing so.

Now, this rate (66 percent paid to providers) could mean nothing unless viewed alongside proportions paid out by HMOs funded with privately paid premiums or a mixture of publicly paid and privately paid premiums.

Of the seven other HMOs active in Mississippi and fitting that classification, six paid more than 85 percent of revenues to providers, some up to 99 or 100 percent. The 85 percent, said the MSMA president, Dr. H. Vann Craig of Natchez, is a benchmark. Spending less than that on patient care, he said, indicates too much being siphoned off to pay executives and stockholders.

American Medical Plan of Mississippi reported enrolling 286 Medicaid patients as its client base and receiving $86,663 to pay their medical expenses - but lists nearly $1.3 million as its administrative outlay.

Now, starting a business isn't cheap, but Dr. Craig was clear about what he thought the numbers showed. "It is a scary thought that a company is willing to come to Mississippi, spend hundreds of thousands of dollars right off the bat, and plan to recoup that cost by reducing medical care to Medicaid costs."

State Insurance Commissioner George Dale, who is not a sworn enemy of HMOs, saw things differently. Sure, the new companies have spread around loot for TV and newspaper ads, billboards, receptions and lots of other things to entice clients. But almost all businesses, including insurance businesses, lose money at first, Dale said.

Well, fine. But nobody spends millions without planning to make millions more. So what this illustrates is something poor folks came to realize a long time ago: Before the Band-Aid gets put on the cut, a lot of chunks will be taken out of the pie full of cash which is supposed to pay for the Band-Aid.

In fact, sometimes people on Medicaid ought to feel lucky if there's any money left at all.

Charlie Mitchell

Managing Editor of *The Vicksburg Post.*

*Reprinted with permission from the **The Vicksburg Post.** ("HMO Figures More Troubling News for the Poor " originally appeared in the September 28, 1997 edition.)*

Salvaging Life From The Grim Reaper

As physicians we have each sworn an oath to serve our patients, to treat their illnesses, and whenever possible to save their lives. Despite our best tests, our best medicines, our best efforts, our sleepless nights, we are not always successful. Indeed, all our patients will ultimately die. The "grim reaper" spares no one in the final accounting. I have never known a physician who is uncomfortable with success, who does not glow with victory when the difficult diagnosis is made, the correct therapies work, and the moribund patient survives and thrives. I have known few physicians who are equally comfortable with death. After all, death for many of us is seen as the ultimate failure... As I have grown older, I have begun to understand that death as failure is a viewpoint peculiar to the medical profession. For patients suffering with dread diseases, death is freedom and an end to pain. For spiritual patients, death is a chance to meet their Heavenly Father and reunite with loved ones. In some cultures, death is a forward motion to a "better place," a "higher level" of existence. It is only for us that death is failure; for others it is painful, it is tragic, it is loss, but it is generally NOT failure."

One way to provide our patients and their families some small good in the setting of death, is to offer the option of organ and tissue donation. Each person who chooses to donate can potentially contribute to life and health in over 100 other people who are waiting for solid organ or tissue transplants. Our "failure" can be less painful not only for the surviving family members, but for us as health professionals when we see other lives saved as organs are shared. Probably only 10-20% of the patients who could donate organs each year become actual donors. Why? Because physicians don't recognize and declare brain death. Because physicians refuse to allow the option to be offered to families (despite federal laws legislating the donation option be offered to all families.) Because brain death isn't understood by families. Because physicians approach families for donation and families feel a conflict (you were trying to save their loved-one's life and now you want their organs?). Because families say no when they have unanswered questions, questions many health professionals may not even recognize exist.

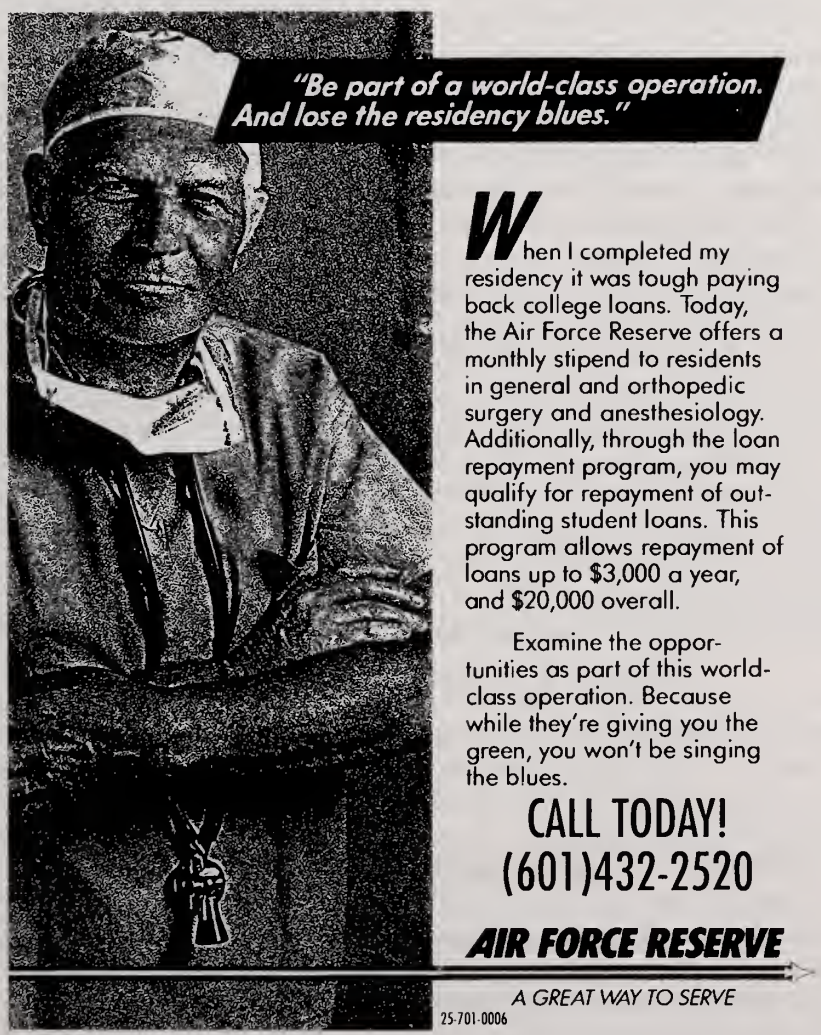
In Mississippi, I hear repeatedly, "The physician has said only the doctor can talk to the family about organ donation," "This patient would be too old (or too sick) to be a donor, don't call the organ recovery agency," or "This patient's family has been through too much, don't bother them about organ donation." Why do we physicians feel WE are the appropriate individuals to approach, or decide "if" families should be approached, about the option of organ and tissue donation once death has occurred? Organ and tissue donation is about disposition of the dead body. How often do we as physicians decide whether our patients will be buried or cremated? Which funeral home the family will use? Which cemetery plot is chosen? I suspect few physicians would consider those decisions their purview. Why is organ donation different? Finally, in 1997, even organs from elderly, infected, hypertensive, brain-dead bodies may be accepted for transplantation. The potential donors physician will generally be unaware of specific recipients' needs. Only the transplant program can decide if the risk of a "marginal" organ is worth taking for a desperately ill recipient. All patients and their families have a right to be given the option of organ donation.

Ideally, considering the option of organ or tissue donation should be a valuable part of the grieving process. The person or persons presenting the option should be trained professionals who understand bereavement, who understand all aspects of organ recovery and distribution, and care enough to spend time with a family helping them to understand and cope with their loss. Donation is NOT the right choice for all families. But studies have demonstrated that the option of donation, when presented correctly, can begin the healing process for all families no matter what their decision regarding donation. Families who choose to donate almost universally find additional peace in that decision. And health professionals who choose to facilitate this option for their patients have the opportunity to find some "success" even in the setting of "failure."

Death Record Reviews in two-thirds of Mississippi's hospitals demonstrate that we are making progress. Thirty-eight solid organ donors in 1996 was a remarkable improvement for our state. But we still have the poorest record of donation in the continental United States. Each of us as physicians can make a difference. Primary care

physicians should be discussing the option of organ donation as part of advance directive dialogues, including the importance of sharing the decision with family members. Emergency room physicians and surgeons must recognize and pronounce brain death when appropriate. Neurologists and neurosurgeons are available in many parts of our state to assist with the management of brain injured patients and are experienced in the diagnosis and declaration of brain death. Our neuro experts must then be willing to call upon the resources of their hospitals and Mississippi's organ recovery agency to offer the option of donation to their patient's families. All a physician actually need do once brain death has occurred, has been documented in the chart, and the family has been informed of the death is to document in the orders: "*Notify MORA of brain death. If family declines donation, D/C ventilator and D/C patient to morgue. If family consents to donation, further orders per MORA personnel.*" Donation should never be a hassle. Patient literature and continuing medical education information is available from the Mississippi Organ Recovery Agency (MORA, 601-933-1000) for physicians who would like to share this information with their patients or learn more personally about these issues. Done properly, approach for consent can be part of the healing we offer our patient's family. In most places, the option of donation is considered the standard of care. Working together, physicians and other health professionals can help it become the standard of care in Mississippi.

Shirley Schlessinger, M.D., Medical Director
Mississippi Organ Recovery Agency, Inc.



Physicians, PAs and the Facts

For the past 30 years PAs have formed successful noncompetitive dependent relationships with physicians. Unfortunately, the success of a 17-year misinformation campaign has distinguished Mississippi as the only state or US territory without enabling Physician Assistant (PA) legislation. The foundation of the PA profession is the dependent relationship that binds the PA to the supervising physician. This foundation was designed by "medicine" and has remained unchanged despite other professional groups seeking the independent practice of medicine. The success of PAs nationally is directly related to embracing the founding principle of dependent medical practice.

The MD/PA relationship was and continues to be emphasized and strengthened by basing PA education on the medical model. Physicians provide the bulk of didactic and clinical education in PA programs. As a result, PA's develop problem solving skills and medical reasoning mirroring that of physicians. In the clinical workplace this leads to a homogeneity of process and philosophy.

PA programs are nationally standardized and accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). An individual must be a graduate of a CAAHEP accredited program to sit for the initial National Commission on Certification of Physician Assistants (NCCPA) examination. In order to enter PA practice an individual must pass the NCCPA examination. Passing the examination entitles an individual to use the designation Physician Assistant Certified (PA-C). In addition, PAs are required to complete 100 hours of continuing medical education (CME) every two years and pass the NCCPA recertification examination every six years.

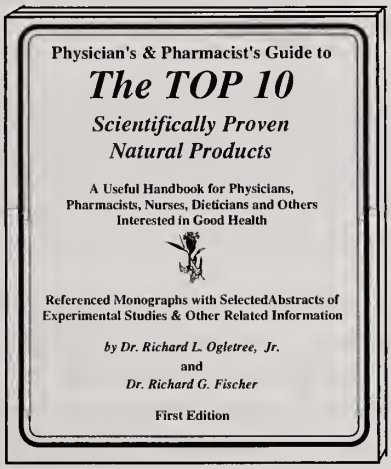
Selection into a PA program is highly competitive. The typical PA student has over 4 years of prior medical experience and has already earned an undergraduate degree or higher. A high percentage of PA students possess a health related professional degree (i.e. registered nurse, pharmacist, physical therapist, occupational therapist, respiratory therapist, medical technologist, social worker, exercise physiologist, etc.) Though the majority of PA programs offer an academic degree it is the certificate denoting completion of a competency based "CAAHEP" approved PA curriculum that validates professional achievement. Many other professions offer competency based degrees. The MD, DO, DDS and JD degrees are familiar examples of competency based degrees. Graduates of accredited PA programs, independent of degree, are required to possess the same level of competency regarding clinical knowledge and skills in order to graduate. Additional assurance of a national standard is obtained by receiving the designation PA-C as previously mentioned. Enabling legislation in 49 states uses the PA-C designation as the determining factor for practice as a physician assistant. State and federal agencies have long recognized that the PA-C, not academic degree, is the *sine qua non* to legal practice as a PA. A detailed description of the PA profession has been clearly stated in the December 1994 issue of the ***Journal of the Mississippi Medical Association.***

The closest primary care PA program to Mississippi is located in Mobile, Alabama at the University of South Alabama. This program has already selected several Mississippi residents as students. It is reasonable to project that Mississippi residents will continue to make up a percentage of each class. These students have expressed the desire to help Mississippi physicians improve access to quality health care. Without enabling legislation this talented resource pool will help extend quality health care in other states.

Including PAs in the Mississippi health care paradigm would favorably impact access to quality care while maintaining physician control. Mississippi physicians should be offered the opportunity to determine the best suited and best trained mid-level provider for their practice and patients.

It is our understanding that PA enabling legislation will be released by the Public Health and Welfare Committee and be voted on in the upcoming 1998 legislative session. We appreciate the past support of the Mississippi Medical Association but now is the time we need increased physician involvement in the political process. The ability of the MD/PA team to improve access to quality health care has been well documented and our students, especially the Mississippi residents, look forward to working with/for Mississippi physicians.

George L. White Jr., PA-C, MSPH, Ph.D.
Professor and Chair
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Annual Health Plan Process Begins

The Mississippi State Department of Health develops a *State Health Plan* each year under the authority of Section 41-7-173(s) and Section 41-7 185(g), and Mississippi Code 1972 Annotated, as amended. The *State Health Plan* has three purposes: (1) to identify priority health needs in Mississippi; (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process to the final adoption of the revised *Plan.*

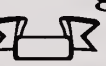
The Process begins each fall with a public forum, held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the *Plan* or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and files the proposal with the Secretary of State. This action initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act. The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "Final adoption" of the revised *Plan.* The Department files the *Plan* as adopted with the Secretary of State.

Staff also obtains up-to-date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the *Plan.* Staff compiles this Formation and produces a final *Plan.* Following approval by the Governor, the revised *Plan* becomes effective July 1 of each year.

Physicians' Recognition Award



Four MSMA members were named recipients of the AMA Physicians Recognition Award in September 1997. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Mississippi Medical Society
Ronald Edward Kennedy, MD
Melinda Sumners Ray, MD

Delta Medical Society
James Vaiden Ferguson, MD

North Central Mississippi Medical Society
Harold David Simmons, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**

Mississippi Institutions and Organizations Accredited as Providers of Intrastate Continuing Medical Education

The following medical institutions or organizations have been accredited as providers of CME by the MSMA's Council on Medical Education. Accreditation is awarded in accordance with the ACCME's/*MSMA's* ***"Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education."*** Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing or calling the Director or Coordinator of Continuing Medical Education at the individual institution or organization.

Baptist Memorial Hospital-Golden Triangle
2520 - 5th Street North
Columbus, MS 39701

Baptist Memorial Hospital-North MS
2301 South Lamar Street
Oxford, MS 38655

Biloxi Regional Medical Center
150 Reynoir Street
Biloxi, MS 39530

Charter Behavioral Health System
3531 East Lakeland Drive
Jackson, MS 39296

Council on Scientific Assembly
MS State Medical Association
735 Riverside Drive
Jackson, MS 39202

Delta Regional Medical Center
1400 East Union Street
Greenville, MS 38704

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

Greenwood Leflore Hospital
1401 River Road
Greenwood, MS 38930

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

King's Daughters Hospital
Highway 51 North
Brookhaven, MS 39601

King's Daughters Hospital
300 South Washington Street
Greenville, MS 38702

Medical Assurance Company of Mississippi
735 Riverside Drive, Suite 301
Jackson, MS 39202

Memorial Hospital at Gulfport
4500 13th Street
Gulfport, MS 39502

Methodist Medical Center
1850 Chadwick Drive
Jackson, MS 39204

MS Baptist Medical Center
1225 North State Street
Jackson, MS 39202

MS State Department of Health/
MS Association of Public Health Physicians
Post Office Box 1700
Jackson, MS 39215

Natchez Regional Medical Center
54 Sergeant S. Prentiss Drive
Natchez, MS 39121

North MS Medical Center
830 South Gloster Street
Tupelo, MS 38801

Northwest MS Regional Medical Center
1970 Hospital Drive
Clarksdale, MS 38614

Rush Foundation Hospital
1314 19th Avenue
Meridian, MS 39301

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39581

St. Dominic-Jackson Memorial Hospital
969 Lakeland Drive
Jackson, MS 39216

Wesley Medical Center
5001 Hardy St.
Hattiesburg, MS 39404

Coding Concepts

In a departure from the usual question and answer format of "Coding Concepts," I would like to take this opportunity to discuss the changes occurring in the documentation guidelines for examinations. Although the new guidelines will not be required until January 1, 1998, physicians will need time to adjust to the new requirements.

According to a spokesperson from the Health Care Financing Administration (HCFA), due to budgeting constraints, your local carriers will not be sending you the new guidelines or offering training. HCFA has stated the new guidelines will be released through speciality societies who have been charged by HCFA to train their members.

This is a vast departure from past HCFA policies. Unlike most changes in HCFA rules, these new requirements will not have a comment or grace period. The guidelines are a result of a two-year process with input from the American Medical Association and specialty societies.

These new guidelines are intended as an extension of the July 1995 Evaluation and Management requirements. They will have far reaching effects as they not only address single organ system exams but also multi-system examinations.

The requirements will be based on the number of areas or systems documented in order to support a particular level of service. The following examples are provided to give practices an insight into the new requirements for multi-system examinations.

Requirements for Multi-system Examinations All Levels

Comprehensive multi-system or level five examinations in any category will require documentation of nine organ systems or body areas with at least two elements per each system for a total of eighteen (18) elements.

Detailed multi-system or Level four examinations in any category will require documentation of twelve (12) elements in two or more organ systems or body areas.

Expanded problem focus (Level Three) examinations in any category will require documentation of six (6) elements in one or more organ systems or body areas.

Level two exams *(expanded problem focus)* will require documentation of one to five elements in one or more organ systems.

Single Organ System Exams

For a single organ system examination, specific guidelines have been developed detailing instructions of what to examine per organ system. A single organ system examination is very extensive requiring an average of 20 documented elements based on the specialty.

However, HCFA and AMA did consider the fact that each specialty is different with differing requirements. Some examples of the differences include:

•Ophthalmologists only have to document 12 elements.

•Neurologists would be required to document 36 elements.

•Cardiologists will have to document an examination of the eyes and eyelids.

•Additionally, many specialty groups will have to document a brief assessment of the patient's mental status.

The following criteria are presented to illustrate the new requirements of a single system exam for a **psychiatric** patient. The following criteria would be required to support a comprehensive consultation, office visit, hospital admission, etc.

Required documentation of positive or relevant negative findings for **each element or line item.**

Constitutional:

Recording of three or more of the following vital signs: 1) blood pressure, 2) pulse rate and regularity, 3)

respiration, 4) temperature, 5) height, 6) weight.

General appearance of patient (Eg. Development, nutrition, body habitus, deformities, attention to grooming).

Psychiatric:

Complete mental status examination including: 1) orientation to time, place and person, 2) recent and remote memory, 3) attention span and concentration, 4) language, 5) fund of knowledge, 6) mood and affect.

Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities.

Description of thought processes including range of thoughts; content of thoughts; abstract reasoning; computation.

Description of the patient's judgement and insight.

Requires documentation of findings for **at least one element or line item.**

Musculoskeletal:

Assessment of muscle strength and tone with notation of any atrophy and abnormal movements.

Examination of gait and station.

Solo practices and emergency department physicians may find it difficult to obtain this higher level of service because of the new documentation requirements. Additionally, physicians who do not dictate or have more modern means of entering findings may find it more increasingly difficult to support the higher examination levels.

Why the drastic definitions? From a carrier's prospective, the E/M codes will be easier to audit since the new guidelines are so cut and dry.

CODING TIP

Keeping current with coding and documentation guideline changes is the key to a reimbursement success for a practice.

Do you have a question you would like answered in the *Journal*? Send your inquires to Wanda L. Adams, CPC, 3280 Lupine Drive, Arnold, MO 63010. Please include your name and phone number should additional information be required.

Wanda L. Adams, CPC, Healthcare Consultant and published author. Founder and past president of the St. Louis Chapter of the AAPC. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of MEDICODE Code Facts.

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Physicians at Risk: Profiling

In health care, as in so many other arenas, knowledge is power. And, with that knowledge usually comes money- a combination that is the likely impetus behind the desire of many health care companies to gather information about physicians. Physician profiles, the product of software programs that analyze physician data entered into billing systems, are currently being used to compare physicians and their practices. These profiles also are commonly the basis for physician deselection from a managed care organization (MCO) or economic credentialing by a hospital.

Given the power and the inevitability of profiling, physicians can best protect themselves by obtaining access to and developing uses for profiling data. In the right hands, profiling can produce useful information which the medical staff organization can use to improve physician performance and patient outcomes. The key is physician access to and familiarity with data collection systems to ensure the data is used appropriately.

Hospital medical staffs may be surprised to know that their hospitals are currently profiling physicians and have been since the early 1980's, when the introduction of Diagnostic Related Groupings (DRGS) significantly affected Medicare reimbursement levels. For the hospital medical staff, profiling can provide helpful, local data for key medical staff functions, particularly quality improvement and professional education. Medical staff quality improvement committees also can integrate profiling data relevant to quality improvement into their activities. For example, profiles that track the length of stay for each admission can provide useful values for economic consideration as well as reveal quality problems such as unduly, lengthy stays or readmission attributable to complications from premature discharge.

Profiling data may also be useful in developing clinical pathways and outcomes measurements for continuous quality improvement. Even data that has no bearing on quality may be advantageous in educating professionals and benchmarking procedures. To the extent that this information is shared with the medical staff for educational purposes, the benefits of improved efficiency and effectiveness of care can be realized by not only physicians and patients, but employers, payers, hospitals/health systems and others as well.

Beyond the direct contribution of information to important medical staff functions, ensuring that the profiling system is shared with the medical staff allows physicians to oversee the process. Thus, they are better prepared to prevent misuses of the data, such as economic credentialing. Moreover, the review of the data by the medical staff should be protected by state law, extending immunity and confidentiality to peer review activities.

Outside the hospital medical staff, but within managed care organizations, physicians and other providers will be subject to comparative analysis based on costs of services attributable to the individual providers directly, or through referrals and orders indirectly. Termination of a contract or "deselection" is the likely result if a provider's profile indicates a cost ratio unacceptable to the managed care organization. The relationship between the physician and managed care organization is strictly contractual in nature. It is rarely protected by bylaws, unless the managed care organization has established a physician organization similar to a medical staff organization or there is an independent practice association or other provider group which has promulgated its own bylaws.

Depending upon the contract signed by the physician, there may or may not be any right to challenge a termination or any means to obtain the information on which the termination was based. The recent case of The Medical Society of the District of Columbia v. Blue Cross and Blue Shield of the National Capital Area provides an interesting overview of profiling by managed care organizations. Blue Cross contracted with an outside vendor,

which used its proprietary software, the Pro/File System, to determine which physicians and other providers would be eligible for the Blue Cross managed care PPO. Eligibility depended upon "cost-efficiency ratings" as determined under the Pro/File System. As a result, no oncologist who practiced exclusively in the District, except the one who was also the Chairman of the Board of Blue Cross, was offered a contract. Forty-two board certified neurologists who practiced exclusively in D.C. were excluded. Two who had D.C. offices were included, but only for those services they provided in their suburban offices. In short, according to the pleadings, the Pro/File System targeted the physicians with the sickest and poorest patients.

Moreover, because the software was proprietary, Blue Cross did not release profiles or the criteria on which the physicians were profiled. This made it impossible to correct inaccuracies, much less challenge deselection effectively. The Medical Society took up the cause, and after months of negotiations, a settlement was reached in which Blue Cross agreed to establish physician committees. These committees had input into and oversight of the selection process and created a hearing process to permit deselected physicians the ability to challenge and perhaps overturn an adverse decision. Physician access to the data was a key victory.

- To effectively harness profiling, physicians should: Obtain access to the profiling system used by the hospital or managed care organization. Information provided to a hospital medical staff organization should be protected by state law; within a managed care organization the contracting physicians should form a medical staff organization or other entity to conduct peer review;
- Request the administration to provide a demonstration of the profiling software used in the billing or other relevant administrative department to disclose to physicians what data are being collected and why; and
- Include provisions in the hospital or managed care organization utilization review plan that ensures the flow of information to the medical staff organization and its appropriate committees. Utilization controls should be subject to clinical oversight to ensure needed care is provided.

Reprinted from the July/August 1997 issue of the American Medical Association Organized Medical Staff Section ***Legal Advisor****.*



The Foundation advocates continuous quality improvement principles and recognizes that continuous quality improvement is as much a philosophy as a practice. It means striving to improve services for patients while looking for ways to be innovative in problem solving to make work more efficient and effective. It also recognizes that because improvement lends meaning to work, individuals are driven to improve against their own performances. Individual effort and leadership are vital to quality improvement; quality can be achieved and sustained only through a team effort. The mission of the Health Care Quality Improvement Program (HCQIP) is to promote the quality, effectiveness and efficiency of services to Medicare beneficiaries by collaborating with providers, researchers, practitioners and other groups in the health care community on projects that identify opportunities to improve the quality of care provided and allow providers to share lessons of best practices with others. The Foundation is currently developing a "web page" on the Internet to further its mission of sharing information and collaborating with others interested in improving the quality of medical care for Mississippians.

EMERGENCY ROOM ACUTE MYOCARDIAL INFARCTION PROJECT REPORT

The Foundation collaborated with 44 Mississippi hospitals in the national Cooperative Cardiovascular Project (CCP), directed by the Health Care Financing Administration (HCFA) to focus on patterns of care for acute myocardial infarction (AMI) patients in Mississippi hospitals. In the CCP, the Foundation recognized that the project did not identify early treatment interventions in smaller hospitals transferring patients from their emergency rooms to larger facilities rather than admitting them. When several smaller facilities indicated their interest in improving their processes involving the use of aspirin and the timing of thrombolytics while patients are in the emergency room, the Foundation initiated the Emergency Room Acute Myocardial Infarction Project (ER AMI).

Recent studies have shown that although increase use and timely administration of blood-clot dissolvers and aspirin can reduce mortality, only a small fraction of eligible heart attack patients are actually receiving these life-saving treatments. The ER AMI project will allow hospitals to focus on improving care for these patients.

Quality indicators created from the CCP were modified after consultation with local experts in the field of cardiology, literature research, and review of current American College of Cardiology guidelines.

For each indicator, specific inclusion and exclusion criteria have been developed.

The denominator for an indicator ratio is the number of patients, with a suspected AMI who meet eligibility requirements. The numerator for an indicator ratio is the number of patients who satisfy the eligibility requirements and also satisfy an additional criterion, such as having received a certain drug.

Through a subcontractor, the Clinical Data Abstraction Center (CDAC), data collection has been performed on 355 AMI patients in 30 Mississippi hospitals for a 12-month period, January through December 1996.

After analysis, the data has been shared with participating hospitals.

Thrombolytics

The study population included all patients with an EKG-confirmed AMI in this indicator.

Patients are categorized into "ideal" and "non-ideal" groups. Non-ideal patients are those with chest pain of cardiac origin with an onset of greater than 12 hours prior to arrival in the emergency room, age over 74 years, increased risk of hemorrhage, history of stroke, use of anticoagulant, recent trauma or major surgery or documentation of refusal of therapy by doctor or patient.

Of 207 patients with an EKG-confirmed AMI, 15.94% received thrombolytics. Thrombolytics were given to 41.67% of "ideal" patients and 10.53% of "non-ideal" patients.

Efficacy: Recent studies have shown substantially lower mortality of acute myocardial infarction with timely administration of thrombolytics in those patients meeting appropriate selection criteria. Reperfusion is not longer considered a research treatment but rather standard emergency department therapy.

Timing of Thrombolytics

The study population included all EKG-confirmed AMI patients receiving thrombolytics in this indicator. Time categories are shown for patients with adequate documentation of the time of arrival and time of administration of the thrombolytic.

Of all AMI patients 12.12% received thrombolytics within 30 minutes of arrival. Data showed that 87.88% received thrombolytics more than 30 minutes after arrival.

Efficacy: Rapid reperfusion with thrombolytics is proven to increase significantly the survival rate for AMI patients. Studies of the timing of thrombolytics identify four critical factors influencing the length of time to reperfusion. One such study categorizes these factors into the 4 D's:

Door: the time from onset of chest pain until patient presents to hospital;

Data: the time required to obtain data (EKG) and document the patient's AMI and clinical status;

Decision: who is allowed to make the decision; studies show faster times when a protocol for immediate treatment by the emergency room physician has been pre-established by the emergency room physician, the attending physician and/or cardiologist; and

Drug: the time required to obtain and administer the thrombolytic to the patient; many hospitals have improved this by placing the drug in the emergency room.

Three of these factors can be directly influenced by the initial receiving facility. The first can be influenced only through patient education and improved emergency response systems. However, this may be improved through involvement in continuing health education and influence on emergency response systems.

When the patient with suspected AMI reaches the emergency department, evaluation and initial management should take place promptly because the benefit of reperfusion therapy is greatest if therapy is initiated early. Optimally, thrombolytic therapy should be started within 30 minutes of presentation.

Aspirin

The study population included all patients for this indicator. Only those patients receiving aspirin 0 to 2 hours prior to arrival or 1 to 24 hours after arrival to the emergency room are counted as receiving the therapy. Patients are categorized into ideal and non-ideal groups. Non-ideal patients include those with active bleeding, history of bleeding diathesis, anticoagulant therapy, history of stroke, allergy or sensitivity to aspirin or refusal of therapy.

Percents of patients receiving aspirin within 24 hours: 55.21% of all AMI patients; 60.97% of "ideal" patients; and 37.21% of "non-ideal" patients.

Efficacy: Studies have shown a reduction in mortality in those patients with an evolving AMI who were treated with aspirin alone and an even greater reduction in those patients treated with thrombolytics and aspirin. If not taken within two hours prior to arrival to hospital, consideration should be given to administration of aspirin to all suspected AMI patients where there are no contraindications. Aspirin should be given orally to patients with a suspected AMI immediately after arrival to the hospital.

For the timing of aspirin, the study population included all patients receiving aspirin for this indicator. Categories include patients receiving aspirin within the following time frames: 0 to 2 hours prior to arrival (1.36%); 0 to 2 hours after arrival (35.45%); 2 to 24 hours after arrival (52.27%); greater than 24 hours after arrival (8.64%) and unable to determine exact timing (2.27%).

Post-Project Monitoring

Post project monitoring is performed by the Foundation 12 months after the provider implements its plan. This measurement, using a statistically significant number of cases, is necessary to determine true improvement in performance. The process involves: identifying the patients treated after implementation of provider QI activities; collecting data from the identified cases using the original data collection instruments; analyzing the data; comparing analysis results with the data collected when the project was initiated (baseline data); and presenting the comparative data to the provider's QI project team and other pertinent staff as reinforcement of improvement activities that work and/or to refine or stimulate new improvement activities for the specific process of care.

Confidentiality of the facilities, physicians or patients is always preserved in group presentations. Only aggregate data summaries and conclusions may be disclosed. Providing direction in the development and implementation of the ER AMI project were consultants Nelson K. Little, MD, cardiology, Oxford; Thomas N. Skelton, MD, cardiovascular diseases, University of Mississippi Medical Center, Jackson; Thad F. Waites, MD, cardiology, Hattiesburg.

Dr. Candace Keller served as clinical coordinator for the project; manager of the project is Sherry Hill, RN. Contact Ms. Hill at 948-8894 for further information.

FMC/BLUE CROSS & BLUE SHIELD SIGN UTILIZATION REVIEW CONTRACT

The Foundation for Medical Care has begun a program of utilization peer review in cooperation with Blue Cross and Blue Shield of Mississippi. Contracts were signed to begin the review in October.

"The Foundation offers an extensive group of experienced physicians to provide this review," said Dr. James S. McIlwain, FMC president. "We look forward to performing the service and conducting this review for Blue Cross and Blue Shield."

At the present time FMC continues to assist Blue Cross and Blue Shield in peer review of appeals for partial psychiatric hospitalization for its Medicare Part A review program.

The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcome.

Randolph J. Ross, M.D., a urologist with Hattiesburg Clinic's Urology Center, performed the area's first PROSTATRON® microwave therapy recently at Forrest General Hospital. The new procedure is designed to treat symptoms associated with benign prostate enlargement. The device uses microwave energy to produce heat that destroys excess prostate cells. It is a relatively painless procedure done on an outpatient basis. The entire procedure takes about one hour and requires no general anesthesia. The prostate gland surrounds the urethra, which carries urine from the bladder. The symptoms occur as growth of the prostate gland places pressure on the urethra. The new procedure allows the patient to avoid the risks of surgery and the higher costs associated with long-term use of medications. During the procedure, a special catheter is passed through the urethra. A balloon on the catheter is inflated to hold it in position and the computer delivers precisely controlled amounts of microwave energy to the prostate gland. The energy results in rapid deep heating that destroys prostate cells. While therapeutic heating is applied to the prostate, a cooling system circulates water through the catheter and temperature readings are constantly monitored. The system maintains desired levels of heat directed to the prostate, while preventing excess heat from affecting and surrounding tissues.

Daniel F. Vial, M.D. has joined the medical staff of South Central Regional Medical Center as a radiologist. He recently completed a fellowship in cardiovascular and interventional radiology at the University of Oklahoma Health Science Center in Oklahoma City. He completed his residency in diagnostic radiology at Texas A & M/ Scott White Hospital in Temple, Texas, where he was also chief resident. Dr. Vial, a native of Hanville, Louisiana earned undergraduate and medical degrees from Louisiana State University. He is board certified in radiology and is a member of the American College of Radiology, the Radiological Society of North America and the American Roentgen Ray Society of Cardiovascular and Interventional Radiology.

Randall S. Hines, M.D., a reproductive endocrinologist and assistant professor in the Division of Endocrinology, Department of Obstetrics and Gynecology at the University of Mississippi Medical Center (UMC) in Jackson, was a principal speaker at the sixth Elliott-Nowell-White Science Symposium at Delta State University. His topic was "Sex Determination: The Real Difference Between Boys and Girls." The symposium is one of three initiatives included in a "Program of Excellence" for Delta State University students giving them an opportunity to interact and learn from scientists of international stature.

Ronald Persing, M.D., adolescent medicine specialist at Singing River Hospital, has given youth in the Ocean Springs area a new way to learn about health care careers and gain important leadership skills along the way by heading up the Medical Explorer Post at Ocean Springs Hospital. With 56 young people signing up to become members, Exploring is the young-adult program of the Boy Scouts of America for young men and women age 14 through 20. Local organizations, such as Ocean Springs Hospital, initiate Explorer Posts by matching their people and program resources with the interests of young people in the community. The result is a program of activities geared to help young adults pursue their special interests, grow and develop. The Exploring program focuses on six key experiences: career, leadership, service, social, physical fitness and outdoors. Dr. Persing headed up the coordination of the Medical Explorer Post and is serving as charter organization representative and has gathered an impressive group of volunteers to advise the new post.

George R. Bush, M.D., ABFP and **J. Ken Grafton, M.D., ABFP** have been recently recertified by the American Board of Family Practice. To receive this certification Bush and Grafton went to Atlanta, Georgia for exams and had to complete 150 or more continuing medical education hours in the past three-year period. Dr. Bush has been with the Westridge Family Clinic, formerly Boone Clinic, for the past 18 years. Dr. Bush is past president of the Mississippi Academy of Family Physicians, a board member of the Medical Assurance Company of Mississippi and a member of the board the Mississippi Wildlife Federation. Dr. Grafton, a native of Laurel, came to Westridge Family Clinic in July 1984. He is past chief of staff of South Central Regional Medical Center and president of the board of Presbyterian Christian School in Laurel.

J. H. "Jack" Scott, M.D. was honored with a reception marking his retirement at the Chamber Center. Dr. Scott's medical career spanned 57 years in Carthage.

Victor Dostrow, M.D. was installed President of the Board of Directors for the Epilepsy Foundation of Mississippi.

Julian Janes, M.D. and **Benton E. Hewitt, Sr., M.D.** were presented Southwest Mississippi Community College (SMCC) Alumni of the Year Awards during an alumni banquet. Though not graduates or students of Southwest, Dr. Janes devoted service as an athletic physician for more than 40 years to earn his honor. Born in Birmingham, Alabama, and reared in Hawkinsville, Georgia, Dr. Janes began his medical practice in McComb in August of 1951 and has been in practice there for 46 years. Dr. Hewitt also has earned the honor through many years of devoted service to Southwest. Dr. Hewitt was valedictorian of his high school class before he entered SMCC in the fall of 1942. In February 1943, however, he was called to serve his country during World War II. He went to basic training with an anti-aircraft division at Camp Stewart, Georgia and was later sent to the University of Georgia under the Army Specialized Training Program. He continued his education at the University of Mississippi and Louisiana State University where he received his medical degree in 1951. After serving his internship at the Baptist Hospital in Alexandria, Louisiana, Dr. Hewitt began his medical practice in Summit in the summer of 1952. He served as SMCC athletic physician from 1952 until his retirement in 1990 for a total of 38 years.

Mark Horne, M.D. recently completed DXA certification curriculum in the practice and interpretation of bone densitometry and has been approved as a certified clinical densitometrist (CCD) by the International Society for Clinical Densitometry (ISCD). ISCD was formed, in part, to enhance the knowledge and quality of densitometry among health care professionals by means of education and quality control measures. An advanced method of determining a person's bone density and bone health, the Osteoporosis Center in Laurel was established for the purpose of practicing bone densitometry, an invaluable diagnostic tool in the fight against osteoporosis.

Robert F. Cooper, III, M.D., who practices in Oxford, recently passed a voluntary on-site, peer-reviewed office inspection conducted by the American Board of Bariatric Medicine (ABBM). Dr. Cooper, III, who specializes in bariatrics (medically-supervised weight control and treatment) and family practice, volunteered to have his office inspected to verify his compliance with the Bariatric Practice Guidelines of the American Society of Bariatric Physicians (ASBP). The ASBP was the first nonsurgical specialty society to develop a Practice Guidelines program for their specialty area and the only organization to implement a program of peer-reviewed office inspections. Dr. Cooper became the 217th physician in the United States to successfully pass an office inspection by the ABBM.

David Doorenbos, M.D. has joined the staff of the Tupelo Neurology Clinic. Dr. David Doorenbos received his bachelor of arts degree in chemistry from the University of Mississippi. He completed his medical studies at the Ole Miss School of Medicine and his internship and neurology residency University of Mississippi Medical Center, where he also served as chief resident. He is a member of the American Academy of Neurology and the Mississippi Neurological Association. He also is a diplomate of the American Board of Psychiatry and Neurology. Before associating with the Tupelo Neurology Clinic, he was associated with the Rush Medical Group, P.A., and served as medical director of the stroke team for the Rush Foundation Hospital in Meridian. He also has been serving as a clinical assistant professor of neurology at the Ole Miss School of Medicine.

Thomas G. Puckett, M.D., CEO of Puckett Laboratory in Hattiesburg, announces his wife, **Meg Puckett,** was installed September 23, 1997 as president-elect of The College of American Pathologists / American Society of Clinical Pathologists (CAP/ASCP) Alliance. The installation was held in Philadelphia, Pennsylvania in conjunction with the fall meeting of CAP/ASCP. The CAP/ASCP Alliance is an organization for spouses of members of the two societies.

Marcus Stanley, M.D. has been recertified as a diplomate by the American Board of Family Practice, the certifying agency for family practice physicians. Dr. Stanley was first certified by passing a written test to gauge his abilities in pediatrics, internal medicine, surgery, obstetrics, gynecology, psychiatry and other aspects of family practice. He is a family physician with The Family Medicine Clinic, an affiliate of the River Region Medical Corporation. He is also certified as an aviation medical examiner.

James L. Burkhalter, M.D., radiologist with The Radiological Group P.A. of Jackson, and with an academic appointment with the Department of Radiology at the University of Mississippi Medical Center, was recently promoted to the position of Clinical Associate Professor of Radiology. Dr. Burkhalter is president-elect/vice-president of the Mississippi Radiological Society, a past president of the Mississippi Ultrasound Society, and is on the staff of Mississippi Baptist Medical Center. He was recently a guest speaker on the topic of "Interventional Breast Ultrasound with Mammographic Correlation" in New Orleans, Louisiana at the annual state technologists' meeting.

Shahzad Khan, M.D. has joined Weems Community Mental Health Center in Meridian as a staff psychiatrist.

Rahul Vohra, M.D., has been named Medical Director of Mississippi Methodist Rehabilitation Center (MMRC). He recently presented "Reflex Sympathetic Dystrophy- Diagnosis and Management," at the Mississippi Workers' Compensation Conference in Biloxi. Dr. Vohra is also Director of the MMRC Stroke Program.

Jeffrey Summers, M.D., a member of the MMRC medical staff, presented "Reflex Sympathetic Dystrophy" at the Mississippi Workers' Compensation Conference in Biloxi.

Stuart Yablon, M.D., Director of the MMRC Brain Injury Program, made the following presentations: "DVT Prophylaxis in Acquired Brain Injury", at the Southern Society of Physical Medicine & Rehabilitation Annual Meeting in Orange Beach, Alabama; a workshop on "Botulinum Toxin Use In Brain Injury/ Spasticity," at the Second World Congress on Brain Injury, Seville, Spain; various workshops covering "Spasticity Training Using Botox," in South America at the Convention Center, San Paulo, Brazil; Rehabilitation Center Auditorium and Centro Estudios Medicos/Instituto de Educacion, Buenos Aires, Argentina; Hotel Bogota Plaza, Bogota, Columbia; and Instituto Neurologico de Antioquia, Medellin, Columbia; a poster presentation: "Utility of the D-Dimmer Quantitative Assay and Impedance Plethysmography in the Diagnosis of Venous Thromboembolic Disease Among Patients with Acquired Brain Injury," at the Association of Academic Physiatrists, in Colorado Springs, Colorado.

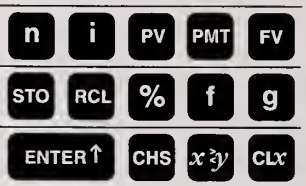
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>
> **The New York Times:** In an editorial, the *Times* criticized policy makers who "*...pretend that physician reimbursements can be cut without affecting health care–as if both doctors and hospitals can be slammed without hurting anyone except the providers of care.*"
>
> **Physician Payment Review Commission:** In its annual report to Congress, PPRC said the current Medicare reimbursement formula for physicians "*...will set increasingly unrealistic target rates of expenditure growth....*"
>
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